HEALTH CARE IN INDIA

George Joseph
John Desrochers
Mariamma Kalathil

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Centre For Social Action
Bangalore

Abbreviations

ANM	Auxiliary Nurse Midwife
CD	Community Development
CHC	Community Health Centre
CHCA	Community Health Care
CHV	Community Health Volunteer
CHW	Community Health Worker
CR	Crore (10 millions)
EPW	Economic and Political Weekly
FP	Family Planning
FYP	Five Year Plan
HS	Health Statistics of India
IA	Ideas and Action
IE	Indian Express
IMR	Infant Mortality Rate
ISM	Indigenous System of Medicine
LHW	Local Health Worker
MFC	Medico Friend Circle
MFCB	Medico Friend Circle Bulletin
MN	Million
MNP	Minimum Needs Programme
MPW	Multipurpose Worker
PBHS	Pocket Book of Health Statistics
PHC	Primary Health Care
PHCA	Primary Health Care
PHSC	Primary Health Sub-centre
VHW	Voluntary Health Worker
WHO	World Health Organisation

Introduction

The Key Issues

Every human being possesses the right to life and health, and to the necessities of life, including proper medical services. The 1948 UN Universal Declaration of Human Rights thus proclaims: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance" (Art. 25). And the Preamble to the WHO Constitution states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

With its commitment to justice, liberty, equality and fraternity, *the Constitution of India clearly recognizes the Government responsibility for health*: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties." It shall, among other things, direct its policy towards ensuring "that the health and strength of workers, men and women, and the tender age of children are not abused", and "that children are given opportunities and facilities to develop in a healthy manner." It "shall make provision for securing just and humane conditions of work and for maternity relief", and for "public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want."[1]

Yet, more than three decades after these and other solemn declarations, *the world at large and India in particular continue to experience "the poverty of health in the midst of scientific abundance",[2] and glaring inequalities in health resources and*

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1. Preamble & Part IV, articles 47, 39, 42 & 41.

standards between nations, regions and classes. While basic health services remain inaccessible to more than two-thirds of humanity and millions of poor die of easily preventable diseases, the rich enjoy ever more specialized facilities. The vast majority of mankind, and of India as well, still suffers from "the diseases of poverty" at a time when the small minority of the rich is increasingly subject to "the diseases of overabundance". Most villages have no proper health personnel and services, while cities are saturated! "In most countries in the world today there is a health crisis... Health which is claimed to be a right of every individual is in reality a privilege of the relatively wealthy and the relatively few."[3]

As a consequence of this overall situation, *health policies, institutions and professionals face a growing storm of criticisms and the need for new alternatives and strategies is more and more widely recognized.* It might be useful to highlight *three key issues* in this complex rethinking process. *First, the question of justice.* According to the World Bank, "present health policies are not only inefficient but also inequitable in most developing countries." Few Governments make rational policies in this field.[4] For the Christian Medical Commission, "a primarily hospital-oriented health care system is... not only ineffective and inefficient but... also unjust", for it does not lead to an equitable distribution of scarce resources.[5] Sara Kaithathara goes deeper and relates the present Indian situation to the functioning of society: "There is an unjust and uneven distribution of health care. The whole health care system is manipulated and held in the hands of the powerful—those who possess the power of wealth, social status, political influence and knowledge, control the planning and distribution of health care. Hence health care is primarily conditioned by the level of per capita income and socio-political power. The poor have no access to health care

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2. This expression is taken from Norman Bethune.

3. Rifkin, p. 9.

4. "Health", pp. 32-3 & 4. On this, see for example H. Mahler, "Justice in Health", in "World Health", May 1978, and T.A. Lambo, "Towards Justice in Health", ibid., July 1979.

5. "Position Paper on Health Care and Justice", in "Contact" 16, 1973, p. 4. On "The Church and Injustices in the Health Sector", see also "Contact" 67, 1982.

in the present economic and political system."[6] As it can be seen, *justice is a central issue in health care.*

Second, the interplay of health and various culturo-religious, socio-economic and political factors. In a well-known textbook, the authors for example assert: "Individual and group health is determined by (a) human biology, (b) environment, (c) ways of living, (d) economic status, and (e) health services."[7] And the 1950 WHO programme declares: "Public health officers have for long affirmed that economic development and public health are inseparable and complementary and that the social, cultural and economic development of a community, and its state of health, are interdependent."[8] The document "Health For All" lists eight dimensions of health—philosophical, cultural, social, environmental, nutritional, educational or promotive, preventive, and curative—, describes at length the interplay of heatlh and economic, social, and political development, and family planning, and recommends an integrated approach to health care. In fact, the health system is but a sub-system in society: while possessing a limited autonomy, it basically reflects the socio-economic, political and ideological systems.[9]

Linking these two insights, the Christian Conference of Asia rightly concludes: "Health IS NOT mainly an issue of doctors, medical services and hospitals. It is AN ISSUE of social justice. It is an issue of who gets what available resources... The health of a people is intimately related to their income, to their education, to their job opportunities, etc. If... poor health

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6. in Volken, "Learning...", p. 64.

7. Park & Park, p. 15. The World Bank thus views the "causes of poor health": "Climate, cultural practices and life styles undoubtedly have an impact on health. However, the socio-economic characteristics of a population have an even more pervasive influence" (op. cit., p. 14; cf. pp. 14-24). This book also points out the importance of political factors (p. 47).

8. Quoted by George Rosen, in "A History of Public Health", MD Publications, N.Y., 1958, pp. 485-6.

9. For these concepts, see John Desrochers, "Methods of Societal Analysis", CSA Publications, Bangalore, 1977, pp. 15-26. For a concrete example, see O.P. Carvajal, "The Health System Within the Structures of Philippine Society", in Rifkin, pp. 21-3.

patterns... are to be changed, then changes must be made in the entire social-economic-political system in any given community."[10]

Third, the need for a positive, dynamic, and multi-dimensional concept of health.[11] Far from being a mere absence of illness, health is a positive reality. It is also a relative and dynamic reality which varies with persons, ages of life, countries, and periods of history. Today's maximum may become tomorrow's minimum! And there is a whole spectrum from severe and incurable sickness to profound well-being! As already pointed out, health moreover comprises many dimensions and should not be understood in predominantly biological, individualistic, clinical, and curative terms. Though not perfect and agreed upon by all, *the 1948 WHO definition of health* is often referred to because it takes into account most of these remarks and sets a positive goal and standard: *"Health is a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity."*[12] A holistic approach to health is essential to grasp the full relevance of CHCA and to reduce the exaggerated importance usually given to medical professionals and costly drugs.

This book provides an overall introduction to the rethinking of health care in India. It answers two major needs by adopting a historico-structural approach to health questions and by giving relevant guidelines for concrete action. It is indeed high time that health professionals come out of the narrow confines of their medical world, become more sensitive to broad social issues, and use the findings of historical and structural studies to guide their societal involvement. And also that many other citizens realize the real, though limited, possibility of improving the conditions of the masses through PHCA, and even of conscientizing and organizing them around health issues. Enough rethinking and experimentation have already taken place to pinpoint the basic issues and alternatives, and to make an enlightened choice in favour of the poor and oppressed. Definite

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10. "CCA, Sixth Assembly, Penang, Malaya, 31 May—9 June 1977", CCA, 1978, p. 114.
11. On this, see for example Park & Park, pp. 14-7, and Bannerjee, pp. 1-4.
12. Quoted by Park & Park, pp. 12 & 715.

possibilities of action have by now emerged to struggle against illness, and against poverty, inequality, and injustice within and beyond the health field.

The first two chapters consider *the history of health care in India.* They show the wide gap between professed ideals and practical planning and implementation, uncover certain forces at work in our society, and raise pertinent questions about past policies and future orientations. Though most Indians and health professionals know little of this evolution, *health theoreticians and policy-makers have become increasingly aware that wrong policies have been followed and that new alternatives and strategies are urgently needed.* This growing consciousness, to a great extent, explains the "Health For All" document. The second chapter analyses whether the recommendations of this report and the new "National Health Policy" go far enough and have a fair chance of being implemented.

The third chapter takes stock of *the present health situation* of our country, while the fourth one identifies the root causes of our failures and makes *a structural analysis of the health system and its history.* In this way, the fourth chapter throws light on the previous ones and deepens our understanding of Indian society and its health system.

The last two chapters describe *what has to be done.* The fifth one broadens the historical background and draws *some important lessons* from the health experiences of various capitalist and socialist countries and the State of Kerala. The sixth and last chapter then studies *the genuine possibilities of action for health workers and social activists in the present context of India. It thus provides key guidelines for relevant health institutions and community programmes, and explains how health issues can contribute to the conscientization and organization of the poor and oppressed of India.* The final conclusion considers *the concrete challenges of these findings,* while the appendix sums up the available information on voluntary health care institutions and the orientation of Christian institutions.

This book does not try to elaborate a national health policy or even some of its main elements. It is rather addressed to ordinary citizens, social activists and health professionals as well as to those responsible for health institutions and projects—to reflect with them on the basic health problems of our country,

to identify various forms or avenues of meaningful action, and ultimately to help them decide their own involvement. *This is why the whole book, but especially the last chapter and the final conclusion, challenges each individual—and each group and institution—with very concrete, and often painful, questions and options. This book is thus mainly written for action-oriented persons and groups who work at the local or intermediary level and are searching for an overall correct perspective.*

Many readers, whether they are health professionals or not, may not be so familiar with the complex issues raised by this historico-structural analysis of health care in India. Some may even be surprised or upset by the dramatic questions and choices confronting the health professionals and institutions, and the social activists, in the present context of our country. May all however have the patience and courage required to face this painful search and take a personal stand! And *may this booklet help many individuals, groups, voluntary agencies, congregations, projects and institutions, to rethink and reorient their action with regard to health!*

1. The Historical Background

After a few words on the traditional systems of medicine and the British period, this chapter describes the development of modern health services in Independent India. It reviews the key orientations of the FYPs and the assessment of their results by special committees and subsequent plans. *This historical sketch shows a striking gap between professed ideals, practical planning and, still more, implementation. It also highlights the country's failure, in its overall process of modernisation, to use justly its resources and to provide basic health care to the majority of its population.* The realisation of these facts brought about, especially in the 1970s, a growing criticism of the prevalent model and a search for new approaches, alternatives and strategies. The history of health care in India is thus very instructive...

The Traditional Systems[1]

Though little is known of health care in the Indus valley civilization around 3000 BC, it seems that health consciousness was rather high, for almost all the households of the excavated city of Mohenjo-daro had wells, drains and bathrooms. India was invaded by the Aryans around 1400 BC and *the Ayurveda system* of medicine came into existence in the Vedic period (up to 600 BC). This "science of life" developed a comprehensive concept of health and saw its golden age between 800 BC and

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1. For details, see D. Banerji, in EPW 1974, pp. 1333-4; L.A.V. Barreto, "Study of Front Line Workers in Different Projects in Rural India", M.D. thesis, Nagpur University, 1979, pp. 12-25; "Encyclopaedia of Social Work in India", vol. 1, The Planning Commission, 1968, pp. 364-5 & 373-8; "Health For All", pp. 98-9; O.P. Jaggi, "All About Allopathy, Homoeopathy, Ayurveda, Unani & Nature Cure", Orient Paperbacks, 1976; R. Jeffery, in EPW 1978, pp. 110-1; J. Nemec, in "Contact" no 58, pp. 3-4; and Park & Park, pp. 2-3 & 672. Most FYPs contain a short section on these systems, and there are also some Government publications. Ayurveda, Unani, Siddha, Homoeopathy, and even Nature Cure and Yoga, are usually grouped as ISMs.

600 AD. The Buddhist kings patronised Ayurveda and established medical schools and public hospitals. Chakara and Susruta respectively compiled their famous treatises of medicine and surgery, "Chakara Samhita" and "Susruta Samhita". During the Moghul period and afterwards, Ayurveda—and its services and training—however declined for lack of State support.

The Unani (or Tibb-Unani, literally, Graeco-Arab) *system* of medicine, which reached its apogee between 800 and 1300 AD, was introduced in India around 1000 AD by the Muslim rulers and, as a whole, enjoyed their support till the advent of the British. In course of time, the Ayurvedic and Unani systems influenced one another. *The Siddha system,* which resembles Ayurveda, is practised almost only in Tamil Nadu. *Homoeopathy,*[2] founded by the German physician Hahnemann (1755-1843), has gained a good foothold in our country. *Nature Cure* and *Yoga* are also popular in some circles.

The British Government adopted an indifferent attitude towards these "non-scientific", "non-modern", systems of medicine. "Let them die naturally" seemed its motto. Interest however grew with the political awakening of India. In 1920 and 1938, the Indian National Congress for example passed a resolution that "an earnest and definite effort should be made by the people to popularise the indigenous system" on account of "the widely prevalent and generally accepted utility of the Ayurvedic and Unani systems."[3] In 1935, some of the Congress ministries in the provinces began to employ traditional practitioners and to establish Ayurvedic colleges. After Independence, the Government clearly favoured the "modern" allopathic system, but also somewhat encouraged the traditional systems and their training and research institutes. A little of integration was also attempted. All this led to some scientific updating and professionalisation, a certain amount of coexistence and competition, and much "medical eclecticism" among people and practitioners. And to many conflicts of values, ideas and interests!

The ISMs have become part of our culture and are very much alive in India today. Though receiving very little of the

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2. Contrary to allopathy, homoeopathy treats disease by drugs that would produce in healthy persons symptoms similar to those of the disease.

3. Quoted by Barreto, op. cit. pp. 19-20.

health budget (Table 2), these systems possess a considerable number of training institutions and, especially, registered practitioners (Table 1). And they probably have almost as many

TABLE 14

The Traditional Systems

	Ayurveda	Unani	Siddha	Homeopathy
colleges (1981)	95*	16*	1*	122
admission capacity	3306	535	75	7513
hospitals (1980)**	242	19	457	61
registered practitioners (1978):				
—institutionally qualified	119,361	10,269	1559	22,919
—non-inst. qualified	105,702	20,185	16,569	81,599
—enlisted	—	—	—	46,619
—total	225,063	30,454	18,128	151,137

unregistered practitioners![5] *It is therefore important to take the present and potential contribution of the ISMs into account in any planning...*

The British Period[6]

The allopathic system of medicine was introduced in South

4. The data on colleges/hospitals and practitioners are respectively taken from HS 1982, pp. 163-4, HS 1981, pp. 179-81 & 185-6, and "Health For All", pp. 238-9. *These colleges function at the undergraduate level. *According to FYP III (p. 652), the ISMs had 98 hospitals, 5372 dispensaries, and 2462 hospital beds in 1961.

5. "Health For All", p. 98.

6. For the rest of this chapter, see the official Government reports —the FYPs and various Committees—and the following books and articles: Banerji (in EPW 1974, pp. 1334-46; Naik, pp. 35-7; and Patel, pp. 3-17); Bannerjee, pp. 10-4; Barreto, op. cit., pp. 26-82; "Encyclopaedia...", op. cit., pp. 365-73; Park & Park, pp. 652-79; K.P. Rao, in "Alternative Approaches...", pp. 191-200; and the documents listed below in footnote 31. Park & Park gives a useful chronology of significant health events.

India by the Portuguese in the early 16th century. Though not superior to the then existing ISMs, Western medicine was spread in our country by the doctors of the East India Company (1600) and the European missionaries. But it is mainly after 1757 that a solid foundation for this system was laid. In the second half of the 18th century, hospitals were indeed established in the major cities of Calcutta, Bombay and Madras, and dispensaries in other key centres. A medical school, started in 1824 in Calcutta, was upgraded as college in 1835. Other medical colleges were soon opened in Bombay, Madras, Hyderabad, Indore and elsewhere. A Royal Commission was formed in 1859 to investigate the causes of the deplorable health conditions of the British army in India. This was followed by the appointment of three Sanitary Commissioners (1864) and a Public Health Commissioner (1869), a Birth and Death Registration Act (1873), a Vaccination Act (1880), a Plague Commission (1904), a Central Malaria Bureau (1910), an All-India Institute of Hygiene and Public Health (1930), a Maternity and Child Welfare Bureau (1931), the Madras Public Health Act (1939), a Drugs Act (1940), etc. The Montague-Chelmsford Reforms of 1919 and the Government of India Act of 1935 progressively decentralised health administration and entrusted greater responsibilities to the provinces. And the Bhore Committee submitted its famous report in 1946. With these measures, the British rulers increasingly recognised the State's responsibility for public health.

The Western system of medicine was primarily intended to serve the British soldiers and civilians stationed in India, but it was also gradually extended to the Indian sepoys, administrators and elite. *Its emphasis was on modern knowledge and technology, urban curative hospitals, and centralised decision-making by professionals. This system hardly reached the ordinary masses* —the villagers especially—, except for some Government campaigns to better sanitation and prevent epidemic outbreaks, and the small overflow of the missionary hospitals and dispensaries. In course of time, "native doctors" were recruited to reduce the work-load of Europeans, and private practice gained ground. In 1947, British India—with its population of 300 mn—"had 17,654 medical graduates, 29,870 licentiates, 7,000 nurses, 750 health visitors, 5,000 midwives, 75 pharmacists and about 1,000 dentists."[7] In spite of these efforts, the National Planning

Commission could thus indict the British policies in 1948: *"The problem of health remained in all its intensity and complexity almost untouched up to the eve of the National Independence..."*[8] This is not surprising, for the British Government in India was not mainly concerned about the development of our country, but with its own political and economic gains.[9]

The Post-Independence Model

The Government of Independent India was confronted with a basic choice: either to expand the existing health services along the pattern set by the Britishers or to make radical changes so as to answer the needs of the ordinary masses. During the freedom struggle, the national leaders had recommended "to develop a National Health Scheme which would provide free treatment and advice to all those who require it", and "to pay special attention to the health needs of the villagers."[10] In spite of similar post-Independence pronouncements, *the political leadership opted, in actual practice, for the first alternative.* This is widely recognised by experts, even of different ideologies. According to Banerji, the Indian leadership "not only perpetuated the old colonial tradition of having an urban, curative, and privileged class orientation of the health services, but it also actively promoted such a colonial outlook."[11] More lately, the "Health For All" report spoke of an "imported and inappropriate model of health services": an "exotic, top-down, elite-oriented, urban-biased, centralized and bureaucratic system which overemphasizes the curative aspects, large urban hospitals, doctors and drugs..."[12]

Let us briefly consider what has happened. *Some rather bold and innovative recommendations had been made just before Inde-*

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7. "Health Survey and Development Committee (1946) Report", vol. 1, pp. 13 & 35, as reported by Banerji, in EPW 1974, p. 1334.
8. Quoted by Barreto, op. cit., p. 29.
9. On this, see for example John Maliekal, "The Independence Movement", CSA Publications, 1980, pp. 4-10.
10. as reported by Banerji in "Seminar" 190, 1975, p. 13.
11. in Naik, p. 35.
12. pp. xi & 10. On this, see also Naik (pp. 3-4) and N.H. Antia (in "Alternative...", p. 102).

The Basic Choice

pendence. The "Health Survey and Development Committee" (Bhore Committee), appointed in 1943, had indeed submitted, in 1946, its comprehensive report on public health, medical care, professional education, medical research and international health. In spite of its serious limitations, the report showed a good understanding of the Indian situation, proposed preventive work as the "foundation" and the "countryside as the focal point", and emphasised the importance of PHCs for providing curative and preventive health services to the rural areas.[12a] *The recommendations' guiding principles were far-reaching and thought-provoking:* interplay of health, overall development, and social, economic and cultural factors; urgent need of reaching out to the vast and more needy rural population; importance of correcting imbalances between rural and urban areas and of en-

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12 a. It might be worth pointing out here that seven "rural health centres"—a concept elaborated in England in 1920 and tried out soon afterwards in USSR—had been set up in India between 1931 and 1939.

suring adequate and free health care for all; emphasis on prevention, promotion, and education; key role of self-help and active cooperation through people's representatives and committees; concept and training of doctor as social physician; etc.[13]

The report visualized the development of PHCs in two phases. In its short-term programme, to be implemented within ten years, a PHC was recommended for every 40,000 population, with a secondary unit as a supervisory, coordinating and referral institution. The number of hospitals and staff members was also foreseen. The long-term programme recommended a PHC with a 75-bedded hospital for every 10,000 to 20,000 population, a secondary unit with a 650-bedded hospital for about 30 PHCs, and a 2500-bedded hospital in each district. Once again, the number of staff members was prescribed at each level. The Committee moreover insisted on the integration of preventive and curative services at all administrative levels and the introduction of preventive and social medicine in all medical colleges so as to prepare social physicians.

The Bhore Committee however possessed some major flaws. First, its targets and outlays were undoubtedly unrealistic. The Committee for example budgeted Rs. 964.72 Cr. for health in the first ten years, while the actual expenditure in the first two FYPs was only 206 Cr. out of a total expenditure of 6632 Cr. The suggested outlay would have constituted 14.5% of the plan expenses instead of the actual 3.1%![14] *Second, the Committee remained vague in its allocations and failed to propose a detailed budget radically redistributing the resources in favour of rural areas.*[15] *Third, the Committee completely bypassed the ISMs, relied only on Western medicine and practitioners, and recommended the abolition of the licentiate course in order to upgrade professional standards and promote equal treatment to all. The goals had to be reached by full-fledged allopathic doctors!* As was foreseen by two dissenting members, Dr. Viswanath and Dr. Bhatt, MBBS doctors did not fit well into the rural scheme...

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13. On this, see Barreto (op. cit., pp. 31-3), Banerji (in Naik, pp. 35-6), and "Alternative..." (pp. 191-2).

14. On this, see "Health Survey..." (Vol. II, pp. 510-1). Barreto (op. cit., pp. 38-9), and HS 1981 (p. 46).

15. "Health Survey...", vol. II, ch. 32.

TABLE 2[16]

HEALTH PLAN OUTLAYS & PRIORITIES

(Rs. in Cr. & % in brackets)

Programme	FYP I (1951-56)	FYP II (1956-61)	FYP III (1961-66)	FYP IV (1969-74)	FYP V (1974-79)	FYP VI (1980-85)	
1. PHCs* & Rural Health,**	25 (17.86)	23 (10.2)	61.7 (18.05)	76.49*** (6.6)	120 3** (5.44)	576.96** (8.54)	
Hospitals & Dispensaries		13 (5.8)		89.29*** (7.7)	132.75 (6)		
2. Control of Communicable Diseases	23.1 (16.5)	64 (28.44)	70.5 (20.63)	127.01 (10.99)	265.09 (12)	524 (7.76)	
3. Education, Training & Research	(21.6) (15.43)	36 (16)	56.3 (16.47)	98.22 (8.5)	111.16 (5.06)		
4. ISM	.4 (.29)	4 (1.78)	9.8 (2.87)	15.83 (1.37)	25.07 (1.13)		720.09 (10.67)
5. Other	20.2 (14.42)	6 (2.67)	11.2 (3.27)	28.19 (2.4)	27.29 (1.23)		

Health sub-total	90.3 (64.5)	146 (64.89)	209.5 (61.29)	435.03*** (37.64)	681.66 (30.86)	1821.05 (26.97)
6. Water Supply & Sanitation	49 (35)	76 (33.78)	105.3 (30.81)	407 (35.22)	1030.68 (46.64)	3922.02 (58.08)
7. Family Planning	7 (.5)	3 (1.33)	27 (7.9)	315 (27.26)	497.36 (22.5)	1010 (14.95)
8. Health total	140 (100)	225 (100)	341.8 (100)	1155.53*** (100)	2209.7 (100)	6753.07 (100)
9. Plan total	2356	4800	7500	15902	39322	97500
10. Health to plan	(5.94)	(4.69)	(4.56)	(7.27)	(5.62)	(6.93)
11. Health sub-total to plan	(3.83)	(3.04)	(2.79)	(2.74)	(1.73)	(1.87)

The political leaders and health planners of Independent India willingly accepted the ideals of the Bhore Committee. The 1st FYP for example referred to the WHO definition of health, saw health as a "vital part" of an integrated and broad programme of social development, declared PHCs "of the highest importance" for the community, and insisted on environmental hygiene, water supply, nutrition, malaria control, and health education.[17] The IInd FYP added that adequate health protection to the rural population was "by far the most urgent need to be met."[18] In practice, however, the leaders felt caught between the "desirable" and the "possible". They legitimately lowered the unrealistic targets and outlays of the Bhore Committee, but they also failed to be more practical and to translate their concern for rural areas into clear budget priorities. *While enthusiastically speaking of humanitarian and even socialist goals, the leaders were thus rather slow in planning and implementing policies that truly benefit the poor of India. They basically accepted the British legacy and strengthened the existing model of health care with its elitist and modernising features.*

Table 2 gives the outlays of each plan on the seven items or sectors of the health budget. Let us begin with *a few general observations*. First, health received a rather low priority in the plan outlays. This is still more striking if one excludes the last two sectors—water supply/sanitation and FP, which were organised and listed separately from the IVth FYP—and takes

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16. This Table was compiled from PBHS, 1975; "Draft FYP 1978-83", pp. 230-5, given in Barreto, op. cit., pp. 76-7; FYP II, p. 52; Draft FYP III, p. 58; FYP IV, pp. 52 & 387; FYP V, p. 154; FYP VI, pp. 382, 385 & 401; and HS 1981, p. 46. We were unable to find some of the figures of FYP VI, because the plan puts the other items together (p. 382). The Annual Plans are omitted. It is only since FYP IV that FP and water/sanitation are listed separately from the other health sub-sections, but we have followed the same division throughout for the sake of comparison. *FYP II & IV distinguish the outlay of the PHCs from that of hospitals/dispensaries. **Rural health was introduced in FYP V as part of the MNP and includes the PHCs' outlay. *** These figures slightly vary from source to source and the totals do not fully tally.
17. pp. 488-524.
18. p. 534.

only the sub-total into account. And the share of health (sub-total) in the total plan budget has considerably decreased from the Ist to the VIth FYP: from 3.83% to 1.87%! Since some of the health outlays remained unspent, the percentage of the actual expenditure is even lower.[19] Second, FP gained some momentum during the IIIrd FYP and consumed an important percentage of the budget from the Annual Plans onward (1966-69).[20] Third, water supply/sanitation was always given a very high priority, but its share became much larger in the Vth and VIth plans. Compared to FP and water/sanitation, the other health items—the sub-total—have lost much ground since the Annual Plans.[20] Four, the control of communicable diseases was given a much lower priority since FYP IV.

Five, a major percentage of the health budget, especially in the first three FYPs, was also spent on items 1 and 3. "Education, Training & Research" mainly deals with research, and the formation of modern health professionals. With regard to "PHCs, hospitals & dispensaries", the available data clearly show that only a minor percentage of the health budget was allotted to PHCs and "rural health". It is also good to point out that, out of the total expenditure (855 Cr) for water/sanitation from the Ist to the IVth plan inclusively, 566 Cr (66.2%) was spent in urban areas and only 289 Cr (33.8%) in rural areas.[21] It is therefore evident that *the health budget did not show any bias in favour of the 80% who live in villages!*

Tables 3 and 4 reveal at a glance *the growth of health institutions and personnel since Independence.* One can see that, while hospitals—73.9% of them were in urban areas in 1981—, medical colleges/seats and health professionals steadily grew, *the rural scheme had a rather slow start.* Only 725 PHCs were started in FYP I; and almost all of them had a too great a coverage and were under-staffed and ill-equipped. While allott-

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19. For details, see HS 1981, p. 46.

20. In the Annual Plans, the percentage of the actual expenditure was as follows: health sub-total (44. 75), water/sanitation (32. 78), and FP (22. 47). On this, see HS 1981, p. 46.

21. FYP VI, p. 397.

22. Compiled from HS 1981, pp. 55, 62, 100, 105 & 112; PHBS 1976 (pp. 50-1), 1978 (pp. 62-3) and 1979 (pp. 57-8); and FYP I (p. 495),

TABLE 3[22]

Health Institutions

At the end of	1950	1956	1961	1966	1974	1978	1981
1. Hospitals	2,014	2,062*	—	—	4,014	6,168	6,670
2. Hosp. beds	106,478	117,222*	—	—	341,064	449,212	466,677
3. Dispensaries	6,587	7,535*	—	—	10,200	12,511	15,968
4. Disp. beds	**7,079**	7,815*	—	—	14,397	—	27,730
5. Hosp./disp.	8,600	10,000	12,600	14,600*	14,214**	18,679**	22,638**
6. Hosp./disp. beds	113,000	125,000	186,000	240,000	355,461**	495,871***	494,407**
7. PHCs	—	725	2,565	4,631	5,283	5,400	5,532
8. PHSCs	—	—	—	17,521	33,509	38,115	51,184
9. Med. Colleges	28	42	57	87	105	106	106
10. Admissions	2,675	3,500	5,800	10,520	12,500	13,000	13,000

TABLE 4[23]

Health Personnel

At the end of	Doctors	Nurses	ANMs
1947	47,500*	7,000*	5,000*
1956	65,000	18,500	12,780
1961	70,000	27,000	19,900
1966	86,000	45,000	22,000
1974	138,000	88,000	54,000
1978	170,000	108,000	71,000
1980	186,000	117,000	77,400

ing 30 Cr for medical colleges, FYP II budgeted only 23 Cr to begin 3000 new PHCs, that is, a meagre Rs. 76,000 per unit.[24] It is not therefore surprising that less than 2000 of them were started... and one can imagine what type of PHCs can be set up with such a budget! In rural areas, in 1981, there were only 1743 hospitals with 62,389 beds, and 11,141 dispensaries with 21,493 beds. *This means that only* 83,882 *of the total* 494,407 *hosp./disp. beds were in rural areas, that is, slightly less than 17%! The percentages of rural beds in 1974 and 1982 were 13.7 and 17.2, which shows a minimal increase in favour of rural areas.*[25] *This also means about 0.17 and 2.5 beds per*

II (p. 534) and III (p. 112). For the 1982 figures, see HS 1982 (pp. 65, 92-3, 97 & 102). Some of the totals given in items 5 & 6 do not exactly tally. The Annual Plans are omitted. *These data represent targets, not achievements. ** These figures are obtained by totalling items 1 & 3, and 2 and 4. *** This figure, given in HS 1978, seems too high.

23. Compiled from HS 1981, p. 55; FYP VI, p. 384; PBHS 1977 (p. 20) and 1979 (p. 26). These statistics refer to "economically active persons". By 1981, registered doctors, nurses and ANMS numbered 268,712, 150,399 and 73,161, respectively (in HS 1982, pp. 2 & 74). The figures for the Annual Plans are not given. *The 1947 statistics are from the Bhore Committee as given in "Health For All", pp. 238-9.

24. FYP II, pp. 536-7.

25. These percentages can be calculated from HS 1976 (pp. 50-1), 1981 (pp. 100 & 105) and 1982 (pp. 91 & 97).

1000 *rural and urban population in 1981.*[26]

The 1961-74 period was characterised by growing unease and more or less important reforms. The Government had appointed in 1959 the "Health Survey and Planning Committee" (Mudaliar Committee) to review the situation and plan for the future. In its 1961 report, *the Committee drew attention to the unequal distribution of hospitals and doctors as well as to the inadequate functioning of the PHCs,* and recommended the opening of new centres only in accordance with the Bhore Committee's standards (I PHC for every 40,000 population) and the upgrading of existing PHCs to that level. The Committee also made suggestions to increase the number and competence of health professionals and, interestingly enough, to train more para-medicals. Unlike the 1946 report, the Committee wrongly stressed the organisation of health services at the district level.[27] The IIIrd FYP similarly highlighted the lack of institutional facilities and health professionals, especially doctors, in rural areas.[28]

Various reforms were therefore progressively introduced, and Committees set up to study key issues. And the need for new types of health workers was gradually recognised. FYP III for example suggested some measures to secure more doctors for rural areas and recommended the use of ISM graduates in PHCs and the organisation of a few short-term course for the training of "medical assistants". Attempts were also made to remedy the "delays in the construction of buildings and residential quarters for staff."[29]—Yet, in 1969, about 50% of the PHCs still lacked hospital buildings, and 75% residential quarters![30]—. In 1963, the Chadah Committee proposed a basic ("multipurpose") health worker (BHW) for every 10,000 population. The 1965 Mukerji Committee however asked for a separate FP staff and the Government approved this policy. More attention was paid to PHSCs after 1966.

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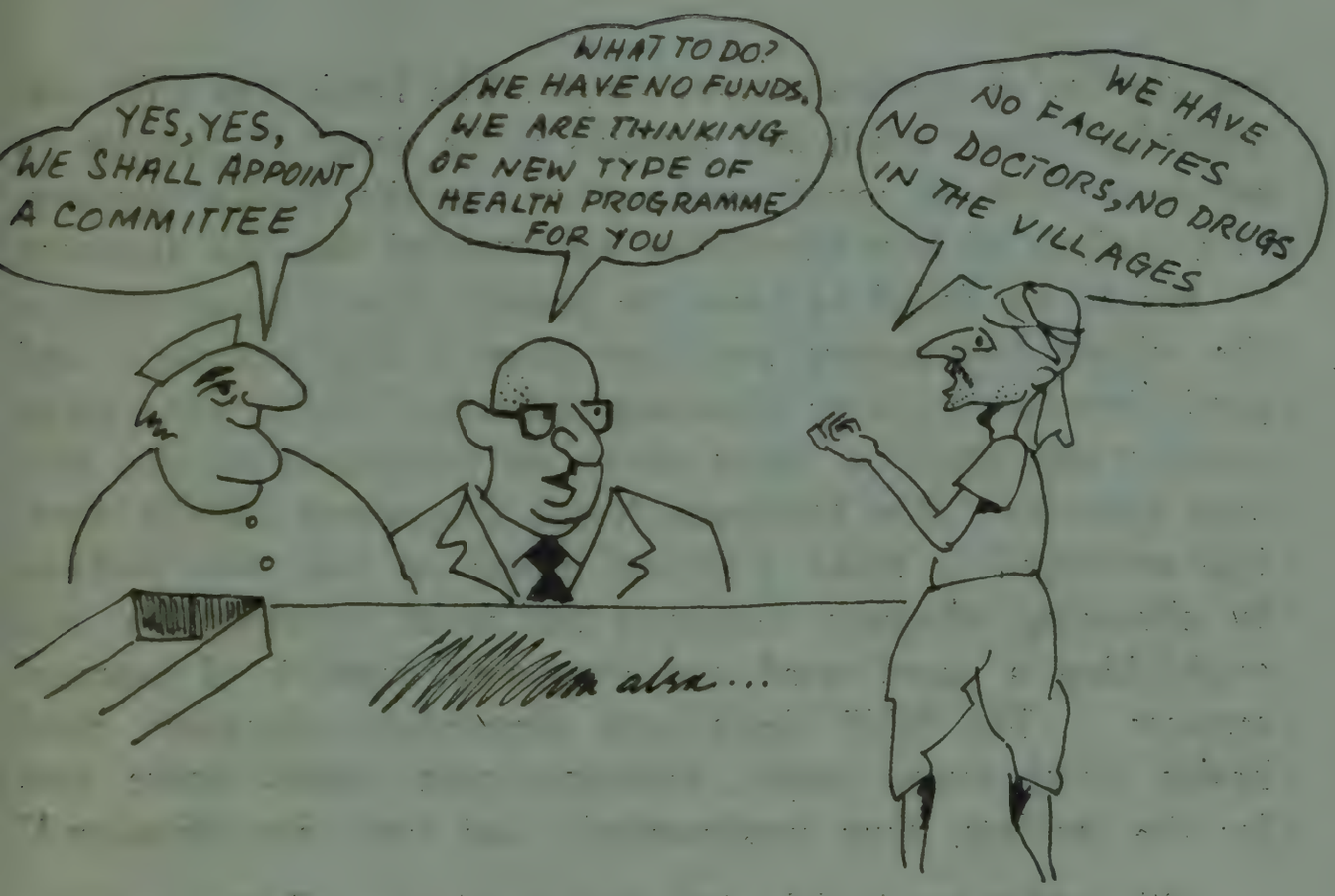
26. The rural and urban population were indeed respectively estimated at 521.541 and 162.268 mn in the 1981 Census.
27. For this paragraph, see "Health Survey and Planning Committee Report", pp. 73-5 & 90-5.
28. p. 652.
29. pp. 657-8 & 662.



Tinkering with the System

Another Mukerji Committee (1966) worked out a scheme of "Basic Health Service" with 1 BHW for 10,000 rural and 15,000 urban population, and the Jungawalla Committee (1967), presented its report on the "Integration of Health Services" at all levels. The "Medical Education Committee" emphasised the need of training basic doctors. To reach out to rural areas, FYP IV allocated separate funds for PHCs, stressed the training of para-medical workers, and began the upgrading of a few PHCs into 30-bedded hospitals. In 1973, the Kartar Singh Committee on "Multipurpose Workers" recommended that ANMs and various types of BHWs be designated as female and male health workers (FHW & MHW), and that I PHC be established for 50,000 population and 1 sub-centre for 3,000 to 3,500 population with 1 FHW and 1 MHW. Though these recommendations were accepted by the Government, there was in 1981 only 1 PHC for about 90,000 population and 1 sub-centre for about 10,000 population!

The search For Alternatives[31]

In the mid-1970s, dissatisfaction became more pronounced,

30. FYP IV, p. 390.
31. Besides the references given in footnote 6, see also "Alternative Approaches...", "Health Services..." (The Shrivastav Report).

and the search for alternatives deeper. The Draft Vth FYP acknowledged that "much still remains to be done" to provide "a minimum level of social consumption" to the weaker sections. "An analysis of past experience has revealed that the approach ... has so far failed to have the desired impact *partly because the related programmes were not given a high priority... and partly because decisions regarding individual sectors were taken without any effort to bring about an integration of the facilities provided."* The Minimum Needs Programme (MNP) therefore envisaged to make a frontal attack on this twin problem by allocating adequate resources for social consumption and establishing a coordinated and integrated network of essential services. The MNP deals with elementary education, rural health, rural water supply, nutrition, rural roads, house sites for the landless, slum improvement, and rural electrification.[32]

The MNP for health aims at "ensuring in all areas a minimum uniform availability of public health facilities, which would include preventive medicine, FP, nutrition and the detection of early morbidity and adequate arrangements for referring serious cases to an appropriate higher echelon." The objectives for the Vth FYP were therefore: establishment of one PHC for each CD Block and of one PHSC for every 10,000 population — the target was to open 101 PHCs, 11,036 PHSCs and 1293 rural hospitals—; making up the building deficiency in existing PHCs and PHSCs; allocation of Rs. 12,000 & 2,000 of drugs per year for each PHC and PHSC respectively; and upgrading of one in every 4 PHCs into a 30-bedded hospital with specialised services in surgery, medicine, obstetrics, gynaecology and anaesthesia. *The nutrition programme* aimed at "taking care of pregnant women and lactating mothers and pre-school children of weaker sections through an integrated programme of supplementary feeding, heath care, immunisation and nutritional education", while *the rural water scheme* was to supply safe drinking water to villages suffering from chronic scarcity or having unsafe sources of water.[33]

Health For All", and the books of Naik, Patel and Bang/Patel. All these are listed in the bibliography.

32. On this, see Draft FYP V, pp. 87-9.

33. ibid., pp. 87 & 89.

In setting up a "Group on Medical Education and Support Manpower" in 1974 (Shrivastav Committee), the Ministry of Health and FP drew attention to the *following problems and needs: "the essentially urban orientation of medical education in India,* which relies heavily on curative methods and sophisticated diagnostic aids, with little emphasis on the preventive and promotional aspects of community health; the failure of the programmes of training in the fields of nutrition, family welfare planning, and maternal and child health to subserve the total needs of the community because of their development in isolation from medical education; the deprivation of the rural communities of doctors, in spite of the increase of their total stock in the society; *the need to re-orient undergraduate medical education to the needs of the country, with emphasis on community rather than on hospital care;* and the importance of integrating teaching of various aspects of FP with medical education." It also stated that "the structure of medical education has to be modified to meet the changing requirements and to provide adequately for future needs, particularly of the rural community."[34]

The 1975 Shrivastav report clearly recognised the need for a new model: "The sheer magnitude of the tasks that still remain is so great and the additional resources available for the purpose appear to be so limited that one almost despairs of meeting our health needs or realising our aspirations on the basis of the broad models we seem to have accepted. *A time has, therefore, come when the entire programme of providing a nation-wide network of efficient and effective health services needs to be reviewed de navo with a view to evolving an alternative strategy of development more suitable for our conditions, limitations and potentialities." It is "desirable that we take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations." "At the community level, what is needed most is not professional expertise so much as nearness to the community, its confidence, emotional rapport with the people, willingness to assist, low cost, and capacity to spare the needed time.* It is, therefore, necessary that some of

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34. "Health Services...", p. 1. For the Government letter, see pp. 45-6. The Vth FYP also affirmed that "*teaching in medical colleges requires a radical change*" (quoted p. 45).

these services should be provided by the members of the family itself and also by part-time trained para-professional persons who operate on a self-employment basis."[35]

In the light of such principles, the Committee recommended four *"major programmes for immediate action"*: (i) organisation of basic health services within the community itself—through semi- and para-professional workers—and training of the personnel needed for this purpose; (ii) linkage of the community with the first referral level centre, the PHC, through multipurpose health workers and health assistants; (iii) creation of a National Referral Services Complex and (iv) of the administrative and financial machinery required for the reorganisation of medical and health education.[36] As a follow-up of these recommendations, the "Community Health Volunteer" (CHV) scheme was launched in 1977 and each medical college was asked to adopt 3 PHCs to provide better health care to the villages and a rural bias to medical education.

The VIth FYP does not mince its words. "With regard to social justice, what we have achieved is far short of what we aimed at." The impact of the social programmes of the IVth and Vth FYPs "seems to be limited". This is evidenced by deficiencies in the health care system: "There has been pre-occupation with the promotion of curative and clinical services through city based hospitals which have by and large catered to certain sections of the urban population. *The infra-structure of sub-centres, PHCs and rural hospitals built up in the rural areas touches only a fraction of the rural population. The concept of health in its totality* with preventive and promotive health care services in addition to the curative, *is still to be made operational. Doctors and para-medicals are reluctant to serve in the rural areas. They are generally city-oriented and their training is not adequately adapted to the needs of the rural areas particularly in the field of preventive and promotive health... The involvement of the people in solving their health problems has been almost non-existent."*[37]

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35. ibid., pp. 4 & 11. According to Naik, the Shrivastav Committee report "is perhaps the first recognition that some alternative or alternatives are needed" (p. 6).

36. ibid., p. 10.

37. FYP VI, pp. 10 & 367.

Table 5 gives the MNP of the VIth FYP on Rural Health: the 1985 targets and the long-term objectives to achieve "health for all" by 2000 AD.

TABLE 5[38]

Rural Health For All & VIth FYP's MNP

Long-term Objectives	1985 Targets
1. One CHV, chosen by the community, for every village or a population of 1000 by 1990. The village will be the base of the rural health care system.	1. To increase the number of CHVs from 1.4 lakh as on 1st April, 1980 to 3.6 lakhs.
2. One PHSC for a population of 5000 in plains and 3000 in tribal and hilly areas by 2000.	2. To increase the number of PHSCs from 50,000 to 90,000.
3. One PHC for 30,000 population in plains and 20,000 in tribal and hilly areas by 2000.	3. To add 600 PHCs and 1000 subsidiary centres.
4. One Community Health Centre (CHC)* for 1 lakh population or one CD Block by 2000.	4. To complete and convert the 340 already upgraded PHCs into CHCs, and to upgrade another 174 PHCs into CHCs.

According to the Plan, *the "health for all" strategy moreover includes the following policies*: (i) shift of emphasis "from development of city based curative services and super-specialities to tackling rural health problems"; (ii) community participation in

38. For this Table and paragraph, see FYP VI, pp. 224-6 & 367-9.

* A CHC is an upgraded PHC—that is, a PHC with a 30-bedded hospital and specialised facilities—that emphasises the public health aspects.

health programmes—The people would "supervise and manage their own health programmes eventually." —; (iii) coordination of various programmes for optimal results; and (iv) training of adequate manpower for the overall programme, and rural orientation of all education and training programmes.

Instead of increasing the number of trainees, the VIth FYP decided to insist on *the qualitative improvement of medical education,* for "many of the young medical graduates, by their background, training and career ambitions find themselves out of place in a rural set up."[39] The rural water supply scheme of the MNP moreover aims at covering almost all the 1.9 lakh problem villages by 1985,[40] while the Special Nutrition Programme intends to add 5 mn children and 5 lakh women to its 8.2 mn beneficiaries, and the Mid-day Meal Programme to better its service of 17.4 mn children.

The last pages clearly show that the inadequacy of the existing health care system and the urgent need for alternatives have been increasingly recognised. With its PHSCs, CHCs, CHVs, etc., the emerging scheme can bring health care closer to the villages than the proposals of the Bhore Committee. The contribution of the ISMs has been, to some extent, rediscovered. Still more importantly, perhaps, health education and community participation are re-emphasised, and the main health agents are not any more restricted to highly specialised professionals, but also include the indispensable local health workers. In our opinion, the emerging model of health care contains genuine possibilities for the rural and urban poor of India.

Do these schemes however remain purely theoretical? Are they translated into outlays, actual expenditures, and concrete achievements? Mainly on account of increased outlays on FP and water/sanitation, health receives a higher priority in the Plans since 1969. *With the MNP, there has also been a certain shift in favour of rural areas in the expenditures.* While FYP IV spent Rs. 22.79 and 165.11 Cr on Rural Health and Rural Water

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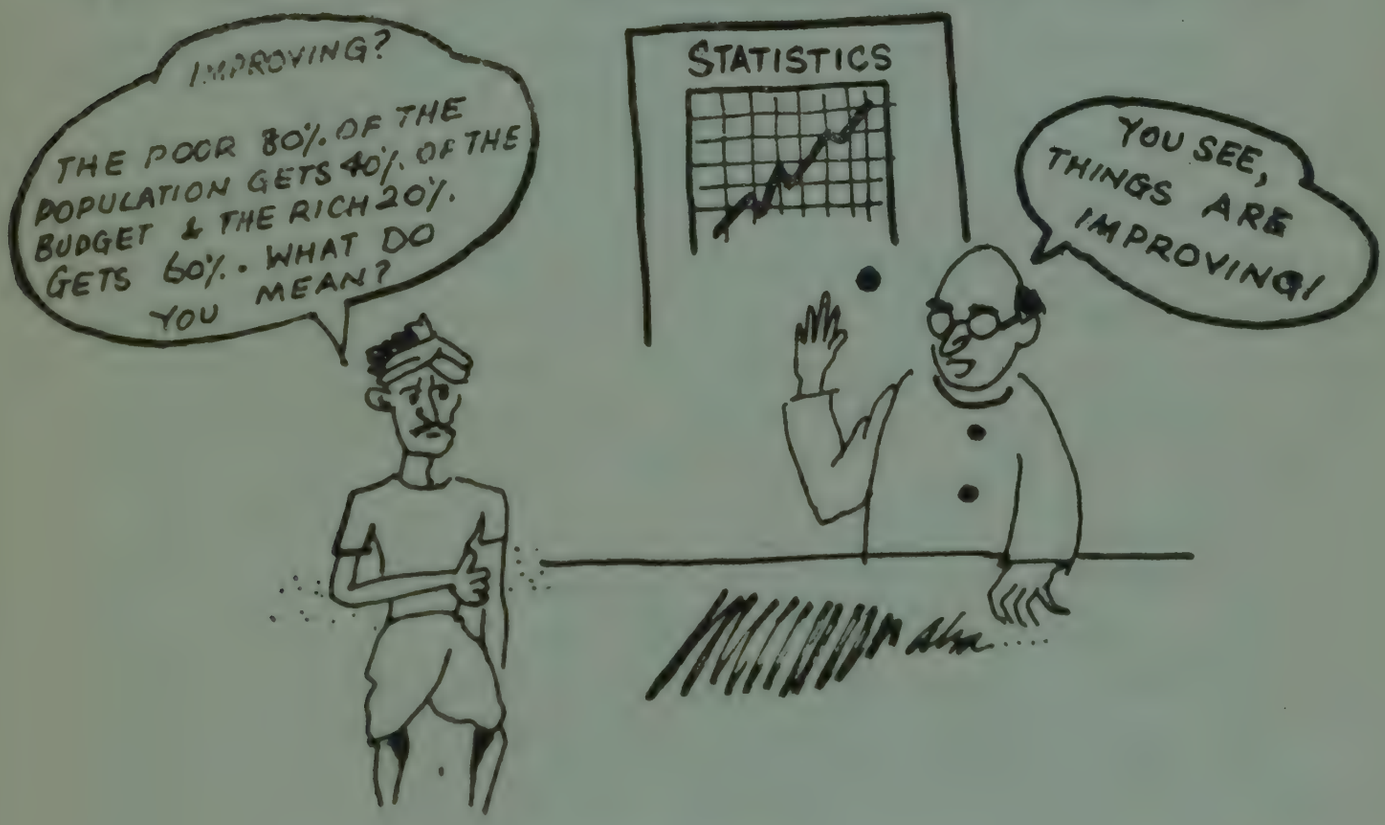
39. ibid., p. 371. For this paragraph, see also pp. 224-5, 377-9 & 398-9.

40. According to FYP VI, previous surveys *grossly* underestimated the number of problem villages, which were also increased by droughts in recent years.

Supply respectively, 107 and 395 Cr was spent on the same items in FYP V, an increase from 17.5% to about 22.7% of the total health expenditure.[41] Since FYP IV was already more rural oriented than the preceding ones, *the shift is somewhat significant. One can however notice that the percentage remains rather* low. The fact that FYP V spent only about 36% and 70% of its outlays on these two items morover indicates that these programmes are not so popular with those who implement them.

The respective outlays of the VIth FYP on Rural Health and Rural Water Supply are 577 and 2135 Cr; [42] these represent 8.5% and 31.6% of the total health budget and a combined 40.1%, which is surely better—if the money is properly spent!—than the 22.7% of the Vth FYP. This limited, but significant, shift of policy and expenditure has also produced *some results*: about 16,000 PHSCs and 1,000 subsidiary centres were opened between



The Meagre Improvements

41. For these figures, see Draft FYP V, p. 88, and FYP VI, p. 223. The last % is calculated on the total health outlay of the VIth FYP, for the total expenditure is not yet available.

42. On this, see FYP VI, pp. 226 & 399.

1974 and 1980, 340 PHCs were upgraded, 1.4 lakh CHVs were trained, etc. And, in the following two years, another 10,500 PHCSs and 622 subsidiary centres were added...[43] One can therefore conclude that, though burdened by a large number of elitist medical institutions and city-oriented health professionals, the Indian Government has at last begun to give more importance to rural areas. *But the efforts remain far from sufficient and the cities still receive, population-wise, six times more than the rural areas.*

A health care system cannot be assessed only, and even mainly, by declarations, outlays/expenditures, and institutional achievements. Having looked at the evolution of health services in India through the eyes of the planners and experts, we must examine the present health situation of our country. This is the best criterion for evaluation. We will make this study in the third chapter after concluding, in the second, our historical survey with an assessment of the new "National Health Policy".

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43. On this, see HS 1982, p. 102 and S. Vaid, in IE, 7 July 1983, p. 8.

2. Health for All

The Indian Government has adopted in August 1983 a new National Health Policy to achieve "Health for all by 2000 *AD".* To understand better this objective and strategy, we will trace the international origins of this idea and analyse the recommendations of the Indian Study Group on "Health For All: An Alternative Strategy". In the last part of this chapter, we will assess the new policy and consider to what extent it is likely to be implemented. This critical appraisal of the National Health Policy will thus conclude the historical study we have begun in the previous chapter.

Origins Of The Idea

WHO was constituted in 1948 as a specialised agency of the UN to promote and protect the health of all people. According to H. Mahler, the Director-General of WHO, the wider dimension of health and the social mission of WHO were "totally neglected" in the 1950s. The organization never dared to say that health should be attainable by everybody, but spoke only of services with as wide a coverage as possible. "WHO did some excellent work, but in some narrow fields." In the 1960s, it was progressively realised that *health services had "failed to bring any organised form of health care to more than half of the world's population living in rural areas and urban slums."* This deplorable situation was highlighted by WHO in the 1970s. In May 1973, the World Health Assembly (WHA) asked that special emphasis be put on meeting *the needs of neglected populations.* A year later, Mahler frankly admitted that the most signal failure of WHO and its Member-States was the inability to ensure basic health services to the masses.[1]

In 1975, the WHO Executive Board and the WHA addressed the same issues and decided to give top priority to *Primary*

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1. For this paragraph, see "Health for All: WHO In A New Role", in "Link", Dec. 6, 1981, pp. 36-7, and "Comprehensive Care with People's Participation", in "The Hindu", Sept. 6, 1978, p. 7.

Health Care (PHCA). *The seven basic principles of this approach* were formulated as follows: "(i) PHCA should be shaped around the life patterns of the population it should serve and should meet the needs of the community. (ii) PHCA should be an integral part of the national health system and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support. (iii) PHCA activities should be fully integrated with the activities of the other sectors involved in CD (agriculture, education, public works, housing and communications). (iv) The local population should be actively involved in the formulation and implementation of health care activities so that health care can be brought into line with local needs and priorities. Decisions upon what are the community needs requiring solution should be based upon a continuing dialogue between the people and the services."

" (v) Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are present in each country. (vi) PHCA should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time. (vii) The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by workers most suitably trained for performing these activities."[2]

Dr. Mahler gave the call "Health for all by the year 2000 AD" at the 1977 WHA. According to him, *"the present realities of the Third World are simply unacceptable.* There is little joy in life now nor any kind of justice for a child condemned to disease or early death because of the accident of birth in a developing country... There is no rationale that can defend

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2. Given for example in Park & Park, p. 696, and "Contact" no 28, 1975, p. 2. Some years ago. Maurice King wrote: "Patients should be treated as close to their homes as possible in the smallest, cheapest, most humbly staffed and most simply equipped unit that is capable of looking after them adequately." ("Medical Care In Developing Countries", Oxford University Press, 1975 edition, p. 1:7).

a system that withholds the gift of health and care from nine-tenths of a nation's population." "Resources distribution in the medical sector is such that 80 to 90 per cent of the resources go to meet 10 to 15 per cent of the health problems."[3]

WHO and UNICEF then organised, in September 1978, *a world meeting of about 700 delegates on PHCA at Alma Ata, USSR.* In the conference working-document, *Mahler and H.R. Labouisse*—the UNICEF Executive Director—*condemned the widening gap between the "health haves" and the "health have-nots", within and between nations.* "Better health could be achieved with the technical knowledge available. Unfortunately in most countries this knowledge is not being put to the best advantage of the greatest number. Health resources are allocated mainly to sophisticated medical institutions in urban areas... The improvement of health is being equated with the provision of medical care dispensed by growing numbers of specialists, using narrow medical technologies for the benefit of the privileged few... At the same time, disadvantaged groups throughout the world have no access to any permanent form of health care." *To change this situation, the authors advocated the alternative approach of PHCA. But they also foresaw the opposition of vested interests*: "Attempts to ensure a more equitable distribution of health resources could well meet with resistance from political and pressure groups and the use of appropriate technology may arouse the opposition of medical industries."[4]

The Alma Ata delegates reflected on the experiences of various countries and voluntary agencies and *strongly affirmed the need of PHCA to achieve an acceptable level of health by all peoples by the year 2000, and to reduce today's gross inequalities,* which are "politically, socially and economically unacceptable."[5] *"PHCA is the key to attaining this target as part of development in the spirit of social justice."* The conference saw health as a fundamental human right and stated that "the attainment of the highest possible level of health is a most important

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3. Quoted in "Link", op. cit., p. 36.

4. Quoted in "The Hindu", op. cit., p. 7.

5. This and the next passages are taken from "The Declaration of Alma-Ata", published by WHO & UNICEF.

world-wide social goal whose realization requires *the action of many other social and economic sectors* in addition to the health sector." It moreover stressed the right and duty of the people to participate individually and collectively in the planning and implementation of their health care, and the Government responsibility to provide adequate health and social measures.

"*PHCA is essential health care* based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through *their full participation and at a cost that the community and country can afford to maintain* at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it *is the central function and main focus,* and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[6]

The Declaration ends with a call to action. "All Governments should formulate national policies, strategies and plans of action to launch and sustain PHCA as part of a comprehensive national health system and in coordination with other sectors." Cooperation between countries, a fuller and better use of the world's resources, and the support of every organisation and individual, are urgently required to translate these principles into dynamic and practical programmes. "In a world in which four-fifths of the population has no access to any permanent form of health care, and in which millions more are disenchanted with the service provided by conventional health systems, PHCA is the key to achieving an acceptable level of health for all."[7]

According to Mahler, *"health for all" means that "there will be an even distribution among the population of whatever health resources are available", and that "essential health care will be accessible to all individuals and families in an acceptable and af-*

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6. The Declaration then explains seven characteristics of PHCA, which resemble the WHO principles we have already quoted.
7. Taken from the WHO/UNICEF introduction to the Declaration.

fordable way, and with their full involvement." The goal is possible, for the world possesses the necessary technology and resources. What is wanted is the political will to use them. The decision-makers and administrators should ask "How should we use the available resources to provide health care to everyone?" instead of "To how many people can we provide good health care?"[8]

The Indian Study Group

A study group on health was jointly set up in 1978 by the Indian Council of Social Science Research (ICSSR)—under its programme "Alternatives in Health"—and the Indian Council of Medical Research (ICMR). It brought "health practitioners and social scientists together to study the social aspects of medicine with a view to suggesting reforms which would lead to the improvement in the health status of the people." The Group issued its non-technical, but rather comprehensive, report in 1981 to initiate a nationwide debate on "Health For All—An Alternative Strategy."[9]

The report emphasises the need for an Alternative National Health Policy to achieve "Health for all by the year 2000 AD." Proposals to transform the country's serious health situation—which is described in detail in the next chapter—"fall into two broad categories. One approach assumes that the existing programmes are, on the whole, moving in the right direction and that what we need is marginal adjustments and changes such as more research, more hospitals and dispensaries, more and better trained personnel, more drugs and, above all, more funds. We do not share this view. *We do believe that several of the assumptions on which the present system is based are wrong."* For instance, there is no distinction between planning for "health" and planning for "health services", little or no attention has been paid to the broad dimensions of health, and health is regarded as a Government responsibility, and not as that of all persons concerned. Besides, the present model of health services is ir-

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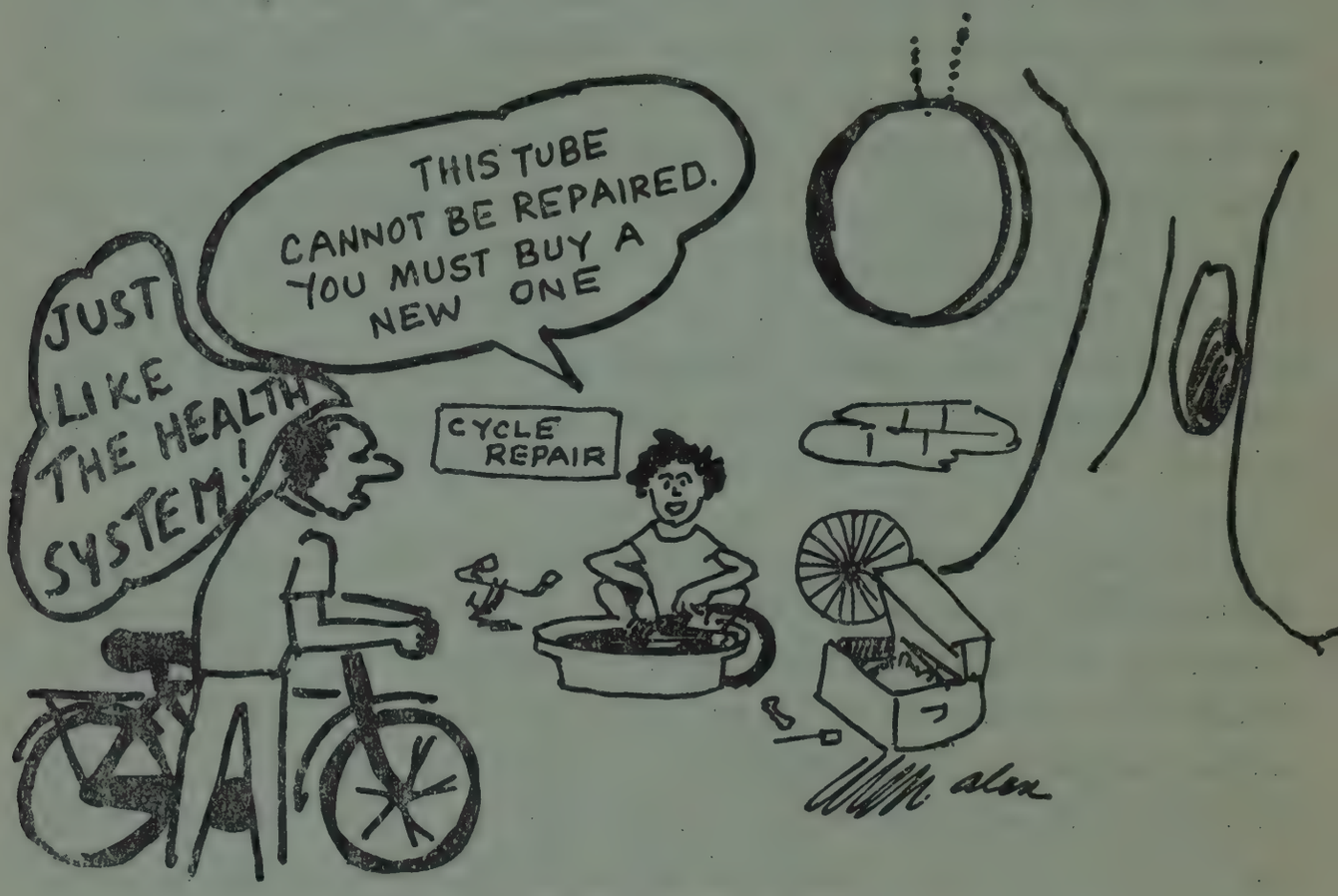
8. Quoted in "Medical Service" no 4, 1981, p. 17, and "Contact" no 67, 1982, p. 4.

9. "Health For All...", Foreword, pp. i-ii.

relevant.[10] *"The serious shortcomings of the model cannot be cured by small tinkerings or well-meant reforms...* Any attempt to pump more funds into a costly and wasteful system of this type will, instead of solving, complicate our major health problems." "Better training, better organisation, or better administration, will also not yield satisfactory results... *What is wrong with the present system is its basic principles and approaches to the health care problem." In consequence, "this model should be totally abandoned and a new alternative model should be created in its place." "Nothing short of a radical change is called for."*[11]



The Need for Radical Change!

The report thus sums up *"what we need without any further delay":* "integrated plans of health and development including FP; total reorientation of the existing priorities so that the bulk of the available funds can be spent (i) on programmes of nutrition, improvement of environment, immunization and education rather than on curative services, and (ii) on basic community services at the bottom than on the superspecialities at the top...;

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10. For some of the report's comments on the various dimensions of health and the present model, see above p. 5 & 13. On the existing model, see "Health For All", pp. 8-9 & 81-4.

11. ibid., pp. 10-1, 84, 217-8 & vii.

replacement of the existing model of health care by an alternative model which integrates promotive, preventive and curative aspects and is community-based, people-oriented, economic, decentralized, democratic and participatory; provision of all the resources needed to achieve these objectives in terms of personnel, materials and funds on a priority basis; and formulation and implementation of detailed plans, spread over the next two decades, for enabling every citizen to have effective health and for creating a healthy society. Nothing short of these radical changes will meet the immense challenges before the country and raise the health status of the people to adequate levels by the turn of the century. A significant first step in this direction would be for the Government of India to enunciate, in consultation with all concerned, a *comprehensive national policy on health...*"[12]

The report develops these insights in its section on the *"basic principles and approaches of the alternative model"*.[13] It may be good to mention a few points which have been so far omitted. CHVs and MHWs are essential to make the health services community-based. To render health services more democratic, decentralized and participatory, they are to be placed under the Panchayati Raj institutions, and paternalistic and elitist attitudes and values have to be transformed. Doctors will share many of their responsibilities and their role will be redefined. The profit-motivated drug industry will not be allowed to have a vested interest in ill-health: the production of drugs will be strictly related to health needs and their costs will be kept low. Adequate support will be given to the ISMs. The health care system will possess a national orientation and critically incorporate the people's values, traditions and culture. It will thus combine the best traditional elements with modern science and technology.

The alternative model will be organized at the following levels: (i) the village/neighbourhood services for 1,000 population; (2) the PHSC for 5,000; (3) the CHC for 1 lakh; (4) the District Health Centre for 1 mn; (5) the Specialist Centres for 5 mn; and (6) the Training, Research and Administrative Insti-

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12. ibid., p. 11; report's emphasis.

13. ibid., pp. 84-102. On drugs and pharmaceuticals, see also pp. 175-86.

tutions.[14] The report also deals at length with FP, nutrition, environment, health education, and certain specific aspects such as services for women and children, control of communicable diseases, personnel and training, research, etc. It finally discusses some administrative and financial issues connected with implementation. *The report asks for a radical change in the health budget.*[15] *Health should first of all receive a much higher priority:* its budget should increase by about 8 to 9% per year (at constant prices) and reach 6% of the GNP by 2000 AD—instead of today's 2%. *The health investment pattern should also be drastically altered in favour of community services and preventive/promotive medicine.* By 2000 AD, about 2/3 of the budget should be spent at the CHC, PHSC and village levels—which would mean about Rs. 19 per person (at present prices) instead of Rs. 3-4 today. *Such a shift will imply the "negative" and difficult decision of not investing more money to expand the present elitist system.* The report moreover points out that the alternative model is less costly and more efficient.

The report strongly emphasises the role of economic and political factors: "The greatest weakness of Indian society today is poverty which compels the majority of its population to live sub-human lives *and the great inequality* between the small privileged classes at the top and the bulk of the underprivileged people at the bottom." The privileged classes hold most of the economic and political power. They also enjoy much better health, for most infectious and nutritional diseases are truly "diseases of poverty". "It is the poor who do not have the capacity to buy food. *The causes of this poverty are economic* (highly skewed structure of income and assets, large incidence of underemployment, unemployment and exploitation), *social* (tyranny of upper and middle classes over the lower ones, high rates of illiteracy and morbidity) *and political* (lack of organisation among the poor)."[16]

"The ideal of health for all is an egalitarian goal which cannot be realised under such adverse socio-economic conditions.

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14. For details, see pp. 103-27.
15. On this, see pp. xiv, 8-9, 11, 85-6, 99-102 & 201-5, and N.H. Antia, in EPW 1981, pp. 1363-4.
16. ibid., pp. 21-3, 17-8 & 41-3.

If one desires to work for it honestly, one must be prepared to look upon poverty and inequality as the worst diseases of the social order which, in their turn, are responsible for several illnesses of its individual citizens. The effort to make every citizen healthy must therefore be developed against the backdrop of our equally intensive effort to cure our society of these basic evils. The reduction of poverty and inequalities can be successfully attempted only through an integrated programme of overall development which is focussed on meeting the minimum basic needs of the common man." *The only way "is to make a direct attack on poverty..."*

"Health for all can only be reached through a fully democratic process: it must be a programme of health for the people, health of the people and health by the people... This will be possible in a democratic, decentralized, and participatory system of government in which the people in a community have the authority, resources and expertise to prepare and implement all plans for their welfare, including health." It is, in short, the overall status of the under-privileged groups that must be changed. "This is basically a political issue and implies the need to take them out of the present marginalised existence and vest them with effective political power. *This can only be done through organisation and political education... This alone will create the foundation on which a good and equitable programme of health services can be built."*[17]

"Health for all by 2000 AD" is a realistic and feasible goal. Some conditions are however essential for success: *"The attainment of this goal depends, above all, on three things*: (1) the extent to which it is possible *to reduce poverty and inequality and to spread education;* (2) the extent to which it will be possible *to organise the poor and underprivileged groups* so that they are able to fight for their basic rights; and (3) the extent to which we are able *to move away from the* counter-productive, consumerist *Western model* of health care and to replace it by the alternative model based in the community... *These are our tasks and it needs millions of young men and women, both within and without the health sector, to work for them.* If a *mass movement* for this purpose can be organised and the people re-

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17. ibid., pp. 23-4, 6, 25-6 & 206-7.

dedicate themselves to the realisation of their national goals, the country will be able to keep its tryst with destiny at least by A.D. 2000..."[18]

People's Organisations

The Pre-requisite for Change

The "Health For All" report surely created more awareness about health problems and policies. Its key insights were generally well received. B. G. Verghese voiced the opinion of many when he stated that this first-cass document lucidly describes the directions and parameters of change. "The alternative model hangs together as a well-integrated scheme which it would be difficult to fault, given scope for adjustments in the light of experience."[19] *Several writers and citizens however expressed doubts about the report's implementation.* P.C. John for example

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18. ibid., pp. 223-4; cf. also, pp. vii & xiv-xv.

19. In "A New Strategy for Health" I & II, in IE, 27 & 28 Nov. 1980, p. 8.

wrote: "The major programs that will improve health are outside the realm of health care per se... As Banerji points out time and again, 'formation of alternatives is essentially a political question' and a structural change in the socio-political systems is a pre-requisite for realising this egalitarian (health) goal... Till such time as agencies in health care delivery, be they voluntary or governmental, realise that formation of alternatives is a political question and that everything else is only a half way measure..., health for all by the year 2000 AD will *remain in the realm of rhetoric.*"[20]

As the Study Group itself recognises, *'the achievement of "Health for all" depends on the realisation of broad socio-economic and political goals. Can we really expect that the "essential conditions for success"—the reduction of poverty and inequality, the organisation of the poor, the creation of a mass movement, etc.—will be met in the near future? If one looks at the overall evolution of the country, the chances do not seem too bright...* But let us consider what is happening!

The National Health Policy[21]

It is enlightening to examine the government stand on "health for all". The Janata and Congress Governments have committed India to the "health for all" goal and strategy by respectively signing the Alma Ata Declaration and the Asian Charter. As already shown,[22] the VIth FYP accepted many of the long-term objectives, basic principles and strategies recommended by the Study Group. It also fixed definite targets for 1985 and allocated a greater percentage of its budget for rural water supply and health. *The Government finally adopted a new "National Health Policy" in August 1983 and re-committed*

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20. in "Link" vol 2 no 1, 1982, p. 3, quoting Banerji (in Naik, p. 45). For a very critical review of "Health For All", see Banerji, in EPW 1981, pp. 1095-1101; and Antia's interesting reply on behalf of the Study Group, ibid., pp. 1363-4.

21. Since the final text is not yet available, we use the 1982 Government "statement..." for our analysis. This document was accepted with minor changes. For a summary and critical evaluation, see Banerji, in EPW 1983, pp. 105-8.

22. See above, pp. 26-30.

India to "the goal of 'Health for all by the year 2000 A.D.' through the universal provision of comprehensive PHCA services".[23]

The policy "confirms the trend in favour of restructuring the health services emphasising community, preventive and promotive health linked to a hierarchy of referral services and integrated with human development and poverty alleviation programmes. People must be required to take health into their own hands through CHVs, traditional birth attendants and practitioners of indigenous medicine, all of them trained and equipped to make appropriate interventions at given levels backed up by supporting services. The effort must be to move from expensive hospital, drug-based, curative services, largely confined to the middle and upper urban strata, to reaching health to the people where they are, and in particular, to vulnerable segments and backward regions..."[24]

After recalling the Constitutional ideals and the country's "rich centuries-old heritage of medical and health sciences", the policy reviews the past achievements. It then recognises that "the demographic and health picture of the country still constitutes a cause for serious and urgent concern". "The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country." The policies have, among other things, resulted in "a cultural gap between the people and the personnel providing care" and in a lack of community participation.[25] *"A thorough overhaul" of the "training of medical and health personnel and the reorganisation of the health services infrastructure" are therefore required to end "the existing all-round unsatisfactory situation" and to "serve the actual health needs and priorities of the country."*[26]

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23. "Statement...", para. 5. Unless otherwise indicated, the following footnotes refer to the paragraphs of this document.
24. editorial, "Act on Healthy Policy", in IE, Nov. 5, 1982, p. 8.
25. 4.
26. 5, 8 & I. 3.

Stressing the need for a "National Population Policy" and a "National Medical and Health Education Policy", and for the revision of health legislation, especially with regard to food adulteration and the quality of drugs, the policy elaborates the well-known principles of PHCA and highights some "problems requiring urgent attention".[27] The document finds it "desirable for the States to take steps to phase out the system of *private practice* by medical personnel in government service". The whole policy also emphasises the need for mobilising the community resources and *the contribution of voluntary agencies.* It moreover insists on "the balanced development of basic, clinical and problem-oriented operational research" and concludes by setting out health and FP goals for 1985, 1990 and 2000.[28]

An analysis of the VIth FYP and the "National Health Policy" however reveals some striking differences with the "Health For All" document. First, the Government emphasis is much more on poverty alleviation, through the MNP for example, *than on the reduction of inequalities and the organisation of the oppressed to defend their rights.* In spite of a few passing references to regional imbalances, *the policy does not speak even once of social justice*—in health and in other fields such as land reforms and wages—*and of people's movements... The "essential pre-requisites" to attain the egalitarian goal of "health for all" are completely bypassed... Second, there is no definite and far-reaching programme to promote community participation in important matters such as finances, administration and health education.* The high-sounding declarations to the contrary thus become mere lip-service and the people's selection of the CHV —when it is done—an isolated gesture. The people "would be entitled to supervise and manage their own health programmes *eventually*", as FYP VI puts it![29]

Third, there is neither talk nor sign of radical change in the health budget. While insisting on PHCA, the policy remains concerned with private practice, paying clinics, and the establishment of specialist centres. *The painful "negative" decisions*

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27. 8-19. These principles are described at length in the previous pages of this chapter and in chapters five and six.

28. 18, 20 & Annex.

29. FYP VI, p. 368.

against the expansion of the present model are nowhere in sight. In fact, in the last few years, at least four prestigious institutes —the Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow, the Indira Gandhi Institute of Medical Sciences, Patna, the Sher-e-Kashmir Institute of Medical Sciences, Srinagar, and the Regional Institute of Medical Sciences, Shillong—have been started. These "white elephants" will cost over Rs. 1,000 Cr by the time they are completed, while the Central Sector of Health has been allotted only Rs 120 Cr for 1982-83.[30] *The "National Health Policy" offers no clear strategies for radical changes and very much lacks a genuine sense of urgency. Fourth and foremost, the new health policy is not an integral part of a broad movement of radical redistribution of economic assets and political power, and of deep transformation of ideas, attitudes and values.* Though praising the "Health For All" document, the reformist Government thus toned it down considerably. *Some meaningful and welcome changes have been introduced, but they are not radical enough to secure "health for all by 2000 AD".*[31]

Whatever might be our reservations about the "Health For All" report and the new "National Health Policy", it has become increasingly clear that the present model of health care has outlived its utility and that the time is ripe to move away from this curative, urban-based and Westernized system. The attainment of "Health For All" is intimately related to the eradication of poverty, inequality and ignorance. *There can be no lasting solution to the country's health problems, unless and until the illnesses affecting the society at large are tackled side by side.* For this, the poor and the marginalized must be organised to fight for their rights and to work for the socio-economic and political transformation of society. These radical changes can only be initiated from below and will be resisted by vested interests. The struggles of people's organisations and movements are therefore essential to build an egalitarian society. Only then can we dream of "health for all."

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30. For details, see S. Vaid, "Lop-sided Priorities in Health", in IE, 30 July 1983, p. 8.

31. Chapters four and six will throw new light on the "National Health Policy". The policy fails to consider the root causes of health problems (ch. IV) and its solutions remain at the level of CHCA without conscientisation/political action (ch. VI, Table 16).

This chapter concludes our historical survey. *The evolution of health services in India betrays the class character of our leadership. Operating in a predominantly capitalist framework and inspired by a modernising ideology, the Government basically developed the Western health care system left by the Britishers. Humanitarian principles and socialist declarations notwithstanding, the health policies of the 1950s and 1960s mainly answered the ideals, aspirations and needs of the upper and middle classes as well as those of the health professionals, and focussed on the provision of hospitals, medical colleges, and curative services, especially in the cities. The rural areas had then to be satisfied with a low-quality and poor-coverage extension of these curative services, and with campaigns against communicable diseases and, later, for FP.*

In the 1960s, the failure of modernization without much social justice became increasingly evident in the society at large and in the health field in particular. Uneasiness and dissatisfaction grew, and *minor reforms were proposed and attempted.* When the societal crisis deepened and these health reforms failed, *the search for new alternatives, approaches, strategies, radical changes, gained ground in the 1970s.* International experiences and ideas had also their impact and a new model of health care progressively emerged. Much progress was made at the conceptual level. *Confronted with growing people's demands, our liberal-minded and reformist Government accepted many of the new concepts and made some significant changes in its policies and budget allocations in FYPs V and VI. It however avoided more radical measures, toned down and delayed various proposals, remained more theoretical than practical and was half-hearted in its implementation. Strong vested interests, a widespread Western ideology, and unjust socio-economic and political structures, make it difficult for the Government to break away from the prevalent model.*

3. The Present Situation

After almost thirty-five years of planning, we may ask whether, and how much, India has progressed. Only true facts can answer this question. Achievements and failures should be neither magnified nor played down, as it is often done. This chapter therefore uses the available data[1] and gives an overall picture of the present health situation, taking into consideration both the achievements and the failures in their naked forms. *Concrete results and hard facts are indeed the best criterion to evaluate our health policies.* An objective assessment is also essential for any plan of action.

The "Health For All" report thus introduces its health survey: *"The overall picture is a mixture of light and shade, of some outstanding achievements whose effect is unfortunately more than offset by grave failures."*[2] Crude death rate, infant mortality rate (IMR) and life expectancy are considered major indicators of the general health status of a country.[3] WHO moreover includes prevention and control of communicable diseases, environmental sanitation, maternal and child care, provision of health services, and nutritional support. We will therefore dwell on these important indicators to review the current health situation of the country.

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1. The data will be mainly taken from HS 1981, FYP VI, "Statement...", and "Health For All", pp. 3-10. For short studies of the situation, see also Bannerjee; "India 1982", Govt. of India, pp. 94-111; "Manorama Year Book 1982", Manorama Publishing House, pp. 544-8; and 1983, pp. 548-57; Naik, pp. 4-5, and Park & Park, pp. 20-1. Though not always accurate, statistics can help us to get a broad picture of the situation. On this question, see Duarte Barreto, "The Indian Situation", CSA Publications, 1977, pp. 5-6.
2. p. 3. Similar statements can be found in FYP VI, Naik, "Statement...", etc.
3. On health indicators, see for example Park & Park, pp. 19-20. The crude death rate represents the annual number of deaths per 1,000 population, and the IMR that of infant deaths (0-12 months) per 1,000 live births.

Achievements

There is undoubtedly a significant improvement in the health status of the country since Independence. As Table 6 clearly

TABLE 6[4]

Health Indicators & Birth/Pop. Growth Rates

Year	Birth Rate	Death Rate	IMR	Life Expectancy at birth	Pop. Growth Rate
1941-51	39.9	27.4	134	32.1	12.5
1951-61	41.7	22.8	146	41.3	18.9
1961-71	41.2	19.00	138	45.6	22.2
1980	33.3	12.4	127	52.1	20.9

shows, the death rate and IMR have steadily declined during the past three decades. And the life expectancy at birth has gone up considerably since 1951. This is an achievement indeed! Modest results are also gradually achieved in FP. Table 6 indicates that the annual birth rate per 1,000 population has fallen by 7.9 points in the 1970s, and the population growth rate by 1.2 points.[5]

There has moreover been immense progress in the control of communicable diseases such as cholera, malaria and smallpox. The country was declared free from smallpox in April 1977. In the early 1950s, there were about 75mn cases of malaria in a normal year and twice that number during epidemics, and about 0.8 mn annual deaths. The incidence was reduced to one lakh

4. Compiled from HS 1981, pp. 22, 28 & 31, and HS 1982, pp. 1, 24 & 28. The latest figures are slightly different in other sources like the "National Health Policy".

5. A recent American study however challenged these figures and pronounced the Indian FP programme an unmitigated flop. For details, see "India Today", March 15, 1983, pp. 144-5. In August 1983, the US Census bureau reported "very little improvement in India's efforts to limit births in recent years" (in IE, 1 sept. 1983, p. 13).

cases with no deaths in 1965, although there was a major upsurge in the subsequent years. Important efforts were made to combat leprosy, tuberculosis and filaria.

The institutional and manpower growth of our health system is impressive. We now have a Ministry of Health and Family Welfare at the Centre and in the States, large departments of public health and medical services in the States, and several medical organisations and institutions.[6] Excellent specialised facilities are available for cardiac diseases, cancer, and neurological and nephrological disorders. A huge infrastructure of hospitals, dispensaries, subsidiary centres, CHCs, PHCs and PHSCs has been built.[7] The number of health professionals and paramedical workers have remarkably increased: doctors, nurses, ANMs, MPWs, etc.[8] In the early 1980s, 117,400 MPWs, 29,879 health assistants, 386,482 dais, and 1.4 lakh CHVs had been trained.[9] The number of institutions and practitioners in the ISMs indicate a considerable, though less striking, growth. Definite efforts were also made to ensure proper standards at various levels. *Though many of these health institutions and personnel serve the upper and middle classes in today's society, they could be put to better use in a different set-up...* The data thus represent a significant growth.

These statistics show a real, but modest, progress in the country's health situation, and a potential for much greater progress if our institutions and personnel are better made use of. We have every right to be proud of these achievements. Yet, one must also look at the negative side of the health situation and acknowledge that *"our failures are even more glaring" than our successes.*[10] "Inside our big hospitals and private nursing homes, we find modern amenities, highly qualified experts. Outside their walls, poverty and disease march bleakly over the landscape."[11] Facts speak this sad picture.

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6. For a list, see for example "Manorama... 1983", pp. 548 & 551-2.
7. For details, see above, pp. 19-22.
8. For details, see above, pp. 19-21.
9. For this information, see HS 1982, pp. 75 & 80, and FYP VI, p. 369.
10. Naik, p. 5.
11. "The Rally", July 1976, cf. C. Behrhorst in "Contact" 20, 1974, p. 2.

Failures and Limitations

A deeper study of mortality rates, disease patterns, and conditions of children and women, reveals a distressing situation. The seriousness of the problem becomes still more striking if one considers the available data on FP, malnutrition and lack of environmental hygiene. The poor coverage and inbuilt inequalities of our health system are other key elements of this deplorable and unjust situation.

Mortality Rates

Table 7 shows that *India's health standards are still extremely low.* Compared to developed countries and several developing countries, the death rate and IMR of our country remain quite

TABLE 7[12]

International Comparisons Around 1978

Country/ Continent	Birth Rate	Death Rate	Pop. Growth Rate	IMR	Life expectancy at birth
Africa	46	17	29	142	49
Asia	31	12	19	93	58
Brazil	37.1	8.8	28.3	77	61
China	26.7	10.2	16.5	45	65
Cuba	28.9	5.9	22.1	19.3	73
Egypt	37.6	10.5	27.1	101.3	53
India	33.3	14.2	20.9	127	52
Malaysia	30.7	6.3	24.4	31.8	53
Pakistan	46.8	16.7	30.1	126	50
Srilanka	29.9	7.8	22.1	45.1	65
USA	15.3	8.8	6.5	14	74
USSR	18.1	9.6	8.5	27.7	70
World	29	11	18	91	61

12. Compiled from HS 1982, p. 24; HS 1981, pp. 189-91; "1982 World's Children Data Sheet", Population Reference Bureau Inc. & UNICEF; and World Bank, "Health", pp. 72-3.

high, and its life expectancy rather low. On all these grounds, the health situation of India is far below the Asian and world average.

Within India itself, there are wide health discrepancies between States, social classes, sexes, and between urban and rural areas. National averages mask all such differences. Compare for example the death rates of Kerala and Goa (7 & 9.2) to those of Rajasthan and UP (15.6 & 20.2). The mortality rate of children under five ranges from 24 in Kerala to 46.4 in Karnataka and 86.4 in UP. The all-India urban death rate is 9.4, and the rural as much as 15.3! Similar inequalities are evident in IMRs. In 1978, this rate was respectively 70 and 136—almost the double! —in urban and rural areas. Between 1970 and 1978, this rate has tended to increase in rural areas, while it has been reduced from 90 to 70 in cities. Since there is a strong cultural bias against female children in most parts of the country, the mortality is also higher among female children.[13]

Women remain seriously underprivileged with regard to health. For almost all age-groups below 40, mortality among females is greater than among males. Maternal mortality is also very high (Table 8). Contrary to all other countries except Bangladesh and Pakistan, India has therefore an adverse sex ratio. The number of women per 1,000 male population has decreased from 946 in 1951 to 941 and 930 in 1961 and 1971, though it has slightly improved to 935 in 1981. Interstate and urban/rural variations in sex ratio are also considerable (Punjab and UP 886, and Kerala 1034).[14]

Disease Patterns

Communicable and preventable diseases still constitute a major health problem in India. Since detailed statistics are easily available,[15] it will be sufficient to give a few examples and to highlight some trends and patterns.

Cholera has considerably declined since Independence, but

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13. HS 1981, pp. 24-5 & 28-9, and MFCB 58, p. 2.
14. HS 1981, pp. 10, 12-3 & 29-30.
15. See for example HS 1981, pp. 115-55; "Manorama... 1982", pp. 545-7, and 1983, pp. 549-50; and "India 1982", pp. 95-7. Unless otherwise indicated, the following data are taken from these sources.

the number of cases (C) and deaths (D) are not yet negligible. The following figures illustrate this evolution: 86,835 (C) and 42,070 (D) in 1951, 47,637 (C) and 16,334 (D) in 1961, 17,140 (C) and 3,595 (D) in 1971, and 8,684 (C) and 306 (D) in 1980. Other water-borne diseases however remain very common. *"Acute diarrhoeal diseases alone are believed to take away 1.5 mn lives every year."*[16] *Malaria* has staged a tragic comeback since 1965. In recent years especially, millions of cases were reported: 3.1 mn (1974), 5.1 (1975), 6.4 (1976), 4.7 (1977), 4.1 (1978), 3 (1979) and 2.3 (1980). The death toll was respectively 3, 99, 59, 55, 74, 198 & 169. In spite of an overall decline after 1976, the North Eastern States, Tamil Nadu, and Andaman and Nocobar Islands showed increasing incidence.[17]

Tuberculosis is another major problem. About 9 mn people presently suffer from active TB, of which 2.2 mn are infectious. In 1980, 6.1 lakh cases and 8,962 deaths were officially reported. The death toll is estimated at about 5 lakhs per year.[18] *India has one-third of the world lepers* and about half of its population is at risk of the disease. According to some estimates, the number of lepers have increased from 3.35 mn in 1971 to 4 mn in 1981—about 25% of them being infectious and another 25% having deformities. More than 40% of India's lepers are in AP and TN. Only 2.37 mn cases were under treatment in 1982. The population at risk of *filaria* has increased from 25.9 mn in 1953 to 236.13 mn in 1976— 174 mn (73.7%) of them in rural areas. And only 24 mn of the urban population at risk was protected in 1980, for there is no effective programme yet for villages! In 1976, 14 mn persons had manifestations of the disease, and 18 mn were with filarial parasites in their blood. It is also estimated that roughly 20 mn Indians suffer from *sexually transmitted diseases* and the number is on the increase. Only 6.8 lakh cases were treated in the few available clinics in 1980!

This list of communicable and preventable diseases could be made much longer... *In spite of all efforts to control them, such diseases have persisted and continue to be the major cause of morbidity and mortality in India. The disease pattern has not*

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16. "Health For All", p. 7.

17. "Manorama... 1981", p. 490.

18. On this, see "Health For All", pp. 6-7, and "India 1982", p. 97.

changed very much.[19] *This is why "Health For All" even states that, in this field, "the main battles still seem to lie in the future."*[20]

There are also many *other serious illnesses.* Let us mention a few. India has 20 mn mentally retarded persons. About 1.5 mn mentally ill people need institutional treatment, and another 3 mn psychiatric treatment. *Out of 9 mn blind persons in the country, about 6 mn could be cured by proper surgery. Every year, 1 mn new cataract cases are likely to be added to the present backlog of 5 mn.* Another 45 mn persons are otherwise visually impaired. While roughly 25,000 children become blind every year on account of vitamin deficiency, 2 to 15% of all children—depending on the region—suffer from milder manifestations like night blindness.[21]

Conditions of Children & Women

Let us complete what we have already said about children and women. *Indian children* below 15 number more than 265 mn in 1983 and constitute almost 40% of the population. Children under 5, who are less than 15% of the population, account for nearly one-third of all deaths. And more than half of the infant deaths (0-12 months) occur in the first month of life. Only 20 to 30% of the babies are born with the help of a trained doctor or midwife. Almost 30% of the newborns weigh less than 2.5 kgs (Table 8)... According to a survey, the average weight at birth is 2.8 kgs among the poorer classes as against 3.2 kgs among the affluent class. The body weight of 75% of pre-school children is below 75% of the standard weight of well-nourished children.[22]

Table 8 shows that the *maternal mortality rate* in India surpasses even that of the average of the developing nations. About

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19. On this, see Bannerjee (pp. 17-9), "Health for All" (pp. 4-5, quoted below, pp. 57-8), HS 1981 (p. 59), and MFCB 58, p. 7.
20. p. 6.
21. For this paragraph, see FYP VI, pp. 367 & 370; "India Today", Nov. 16, 1977, p. 29; and "Health For All", p. 38. For a Table on handicapped children per 100,000 children, see HS 1981, p. 198.
22. For this paragraph, see HS 1981, pp. 18 & 30; "Health For All", pp. 4 & 230; and "Socialist India", Feb. 25, 1976, p. 6.

TABLE 8[23]

International Comparisons

	India	Developing Countries	Developed Countries
1. Infant mortality	125	96	20
2. % of newborns weighing less than 2.5 kgs	27.5	18	9
3. % of anemia among pregnant women	70	60	20
4. Maternal Mortality per 100,000 live births	418	400	20

60,000 Indian women die every year in the course of childbirth or soon after. Anemia among pregnant women is also very frequent and causes almost 20% of the maternal deaths. It is estimated that about 6 mn abortions take place annually, 4 mn of them induced and the rest spontaneous. One seventh of those who become pregnant resort to illegal abortion at the hands of unqualified/unscrupulous persons with harmful consequences for morbidity and mortality. Almost 10% of the maternal deaths are due to abortion. [24]

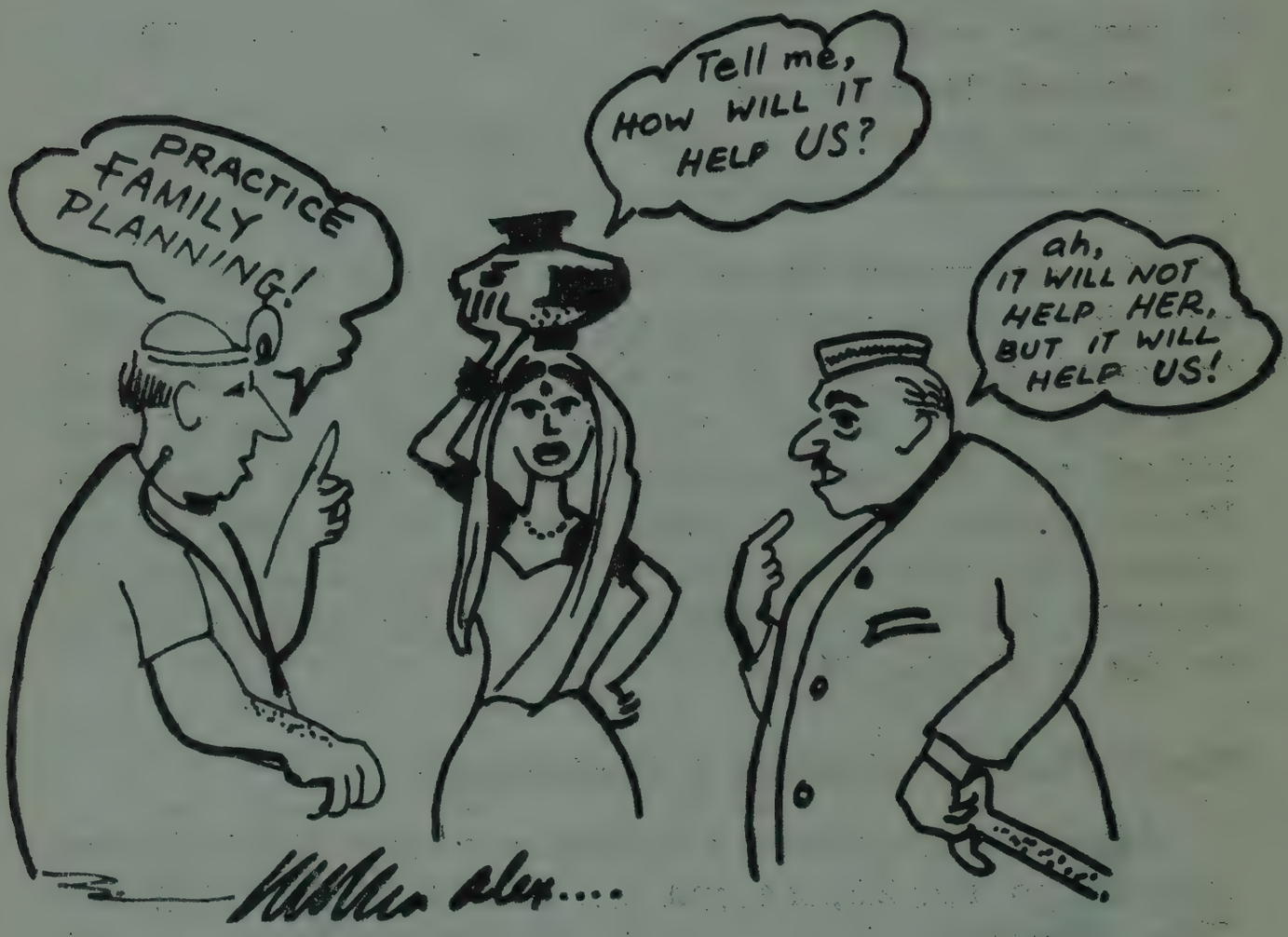
Family Planning, Nutrition & Environment

Married Indian women still have an average of 4.8 children compared to 1.9, 2.3, 2.4 and 2.5, in USA, Cuba, USSR and China respectively. Table 7 shows that India's birth rate and population growth rate are slightly higher than the Asian average. *The reduction in these areas has also been very slow,* even after 1966 when the FP campaign was in full swing (Table 6). In fact, the 1981 Census found that India's population has exceeded the projected total by more than 11 mn and that the 1971-81

23. Taken from the Govt. report to the UNICEF/WHO meeting on "health for all", New Delhi, 1982.

24. On this, see HS 1981, p. 160; and MFCB 23, p. 3.

growth rate (24.75%) has been practically the same as in 1961-71 (24.80%). Instead of decreasing from 35 to 30 as per the target of the Vth FYP, the birth rate was as high as 33.3 in 1980. The percentage of couples in the reproductive age-group effectively covered by the FP campaign even came down from 23.9% in 1976-77 to 22.5% in march 1980! FYP VI aims at an ambitious 36.6% coverage by 1985, but the country had achieved only 25.9% in march 1983. *We are therefore very far from the targets set for 1985!* And the economic and health situation can hardly improve if the country does not control its population. [25]



Since almost half the Indian population remains below the poverty line in the 1980s, it is not surprising that

25. On this, see FYP VI, pp. 373-4; "Manorama... 1982", pp. 375-6; HS 1981, pp. 2, 12 & 16; and "Planners doubtful of hitting FP target"—a report of the mid-term appraisal of FYP VI—, in IE, 1st Sept. 1983, p. 6. So far, "it has been possible to achieve only 36.7 per cent of the plan targets for sterilisations and 30 per cent for IUD insertions..."

malnutrition estimates arrive at rather high figures. Social scientists do not however agree on food requirements and malnutrition criteria, and their estimates consequently vary between 15-25%—this is P.V. Sukhatme's controversial opinion—and 50%. It might be good to mention here the findings of a few studies. An "estimate of nutritional inadequacy for 1971-72 based on a calorie norm of 2300 calories and a protein norm of 57 grams shows that the percentage of population suffering from either calorie or protein deficiency (or both) was 28.8% in rural areas and 32.6% in urban areas." "The surveys conducted by the National Institute of Nutrition, Hyderabad, show that almost 4 out of 10 rural households consume diets which do not meet their calorie needs; and the available data on urban slums show that the malnutrition there is in no way less than that in rural areas."[26]

Malnutrition evidently varies according to place and time It is moreover concentrated in certain social groups—such as agricultural labourers and Scheduled Castes & Tribes—and in some "vulnerable groups" (children below five and pregnant and lactating women). The Hyderabad Institute for example "reports that 65% of India's toddlers (age group 1 to 5) in the lower income levels, suffer from moderate malnutrition and 18% from severe malnutrition. In March 1973, the Health Minister said in the Lok Sabha that about 60 mn children of this group are badly undernourished. *The reason is not protein starvation as some UN reports suggested but overall calorie starvation."* "Iron deficiency anemia is seen in almost 50% of children below the age of 5 years and in 30 to 43% of women during their reproductive life." On account of various cultural factors, the nutritional status of women, especially from the lower sections, is far from satisfactory and their special needs during pregnancy and lactation are often ill-understood.[27]

The importance of environmental hygiene is recognized by all. It has even been estimated that 60 to 70% of India's health problems would disappear with safe drinking water and sound

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26. FYP VI, pp. 7 & 377, and "Health For All", p. 40.

27. "Manorama... 1982", p. 549, and "Health For All", pp. 38-9 & 46-7. On the effects of malnutrition, see D. Barreto, "The Indian Situation", op. cit., pp. 20 & 48-50.

sanitation. *Table 9 tells us how deplorable and alarming is the situation!* About 83% of the urban population has some provision for protected water supply, but "only about 64,000... (10.4%) villages have adequate water supply of acceptable quality (40,000 of them have been provided with these facilities during the plan periods). About 214,000 (34.7%) villages have adequate supply but with pollution risk; 185,000 (30%) have adequate but unprotected sources; and 153,000 (24.9%) are

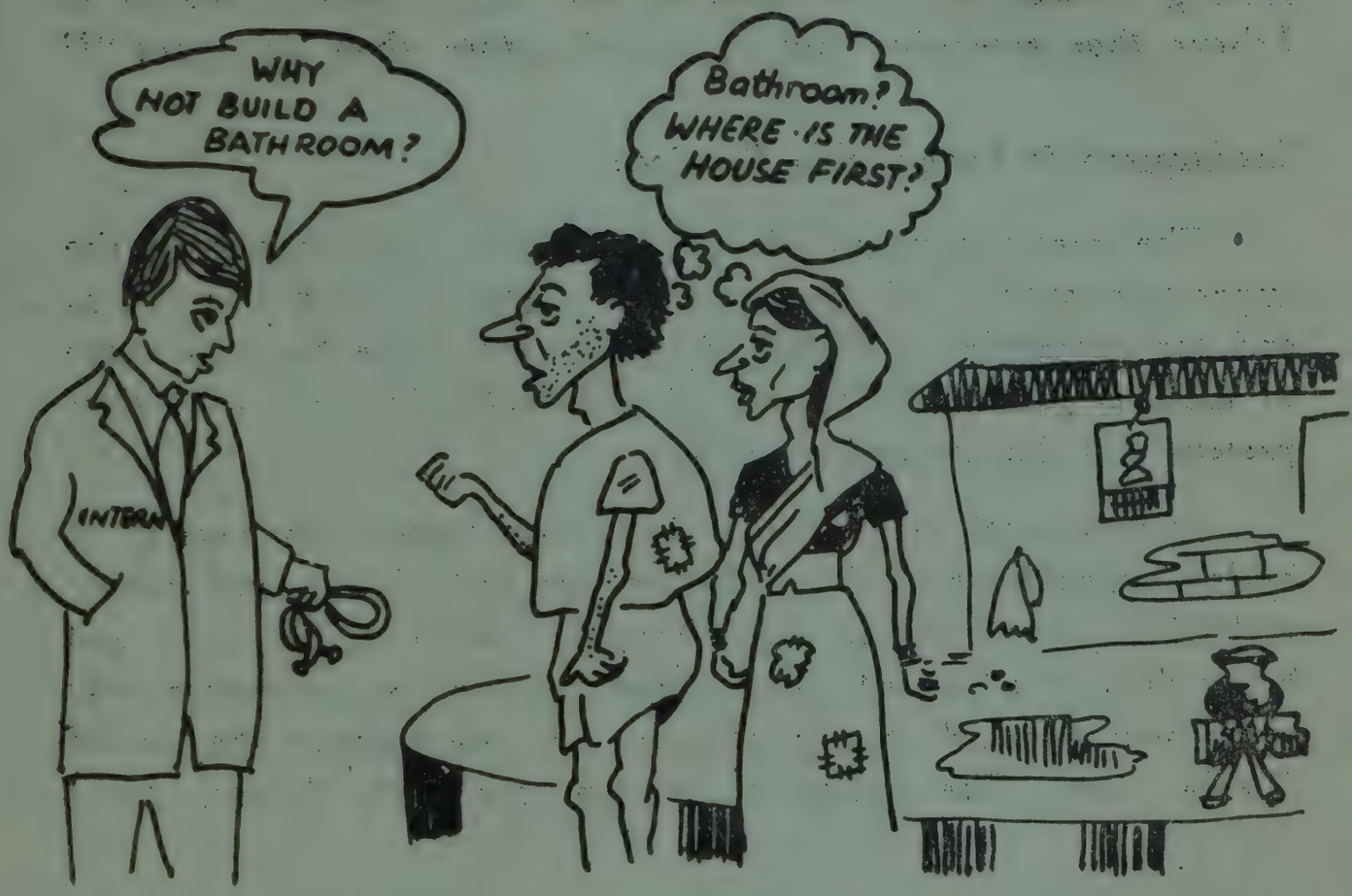
TABLE 9[28]

Water Supply & Sanitation

		Population (%)
Protected water supply	Rural	10
	Urban	80
Sound excreta disposal	Rural	2
	Urban	34

problem villages (i.e. villages with inadequate water supplies or infested with endemic cholera, guinea-worm and other health hazards)."[29] More recent findings have even listed 1.9 lakh villages in the last category![30] *With regard to sanitation, the situation is still worse.* In urban areas, about two-thirds of the population have no sewerage services and as much as 25-40% of the night soil and 40-60% of the solid wastes remain uncollected. *And "not even a meaningful beginning has been made in rural areas"*, which are probably less sanitary than in previous generations.[31]

28. Taken from the Govt. report to the UNICEF/WHO meeting, op. cit. As can be seen from the text, other estimates give slightly different figures. According to the "Statement on National Health Policy", "only 31% of the rural population has access to potable water supply and 0.5% enjoys basic sanitation".
29. "Health For All", p. 54. We have added the percentages.
30. See above, p. 28.
31. For more details on environmental questions, see the excellent chapter of "Health For All", pp. 53-66.



Health & Poverty!

Let us conclude our review of the health situation with the following words of "Health For All": "The current morbidity and mortality picture shows *one major variation from the past.* Famines no longer take the toll they used to; smallpox has been eradicated; cholera and malaria have been curbed; and immunization has protected (many) children from dangerous childhood diseases like smallpox, whooping cough, diphtheria, tetanus and polio. But, *in other respects, the overall character of morbidity has not changed much.* Diseases arising from poverty, ignorance, malnutrition, bad sanitation, lack of safe water supply, drainage or inadequate housing, and low levels of immunity are still the most. common. These include tuberculosis, gastroenteritis, malaria, leprosy, filariasis, etc. (which rarely occur in the developed nations) and measles, tetanus, whooping cough, bronchitis and pneumonia, scabies, worms and fevers (especially among children). *It appears that although the average Indian may now live longer, his morbidity is only marginally less than that of his forefathers and he continues to be largely prone to the same diseases as they were.* While children are being saved from death, the problem of the surviving children with severe physical and mental retardation is one of considerable magnitude...

Among at least some sections of the poor, there is reason to believe that morbidity has increased rather than decreased."[32]

Inadequate & Inequitable Services

• The previous pages of this book have described both the impressive growth of our country's manpower and institutions and the miserable conditions of our people. Time has now come to make *a general assessment of our health facilities with their present distribution and coverage.*

International comparisons are often made with regard to health expenditure, and population per bed, doctor and nurse/midwife. Though taking only Western criteria into account and being thus of a limited value, *these comparisons somewhat indicate how unequal health services are throughout the world* (Table 10). The Indian population per bed, doctor, nurse

TABLE 10[33]

International Comparisons around 1977-81

Country	Population Per Bed	Doctor	Nurse/ Midwife	Per Capita Govt. exp. on Health (US $)	Health to total exp. (%)
Brazil	240	1,650	2,280	20	8.5
China*	2,941	3,224	—	—	—
Cuba*	213	1,199	—	—	—
India	1,436	3,600	5,600	0.91*	1.64
Malaysia*	270	7,300	840	15	6.41
Pakistan	1,740	3,490	4,190	1	1.35
Srilanka	350	7,400	1,550	5	8.1*
USSR	80	290	160	47*	5.8*
USA	160	520	140	179	10.48

32. pp. 4-5. We have added the bracket (many).

33. Compiled from HS 1982, pp. 174-5, and World Bank Paper, "Health", pp. 74-5 & 78-9. * These figures are for 1971-73.

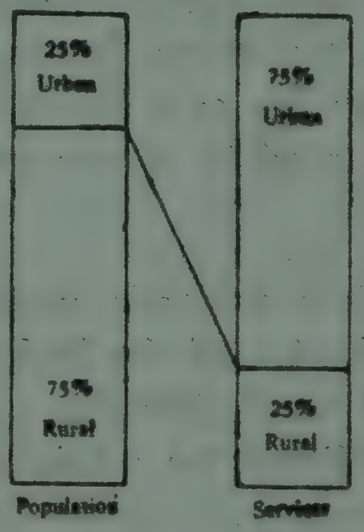
and ANM is also still considerably higher than the norms set by the 1961 Mudaliar report, which were 1,000, 3500, 5000 and 5000 respectively.[34] In fact, *India needs many more nurses*, for there should normally be 2-3 nurses per doctor.[35] *And many more ANMs. Table 10 moreover shows that India's health expenditure is comparatively very low.*

It is however more essential to analyse the distribution of health personnel, services and finances in India itself. Table II enables us to consider at a glance much of the available data on urban/rural inequalities. Though these statistics are only ap-

TABLE 11[36]

Urban/Rural Inequalities (%)

	Urban	Rural
Population (1981)	23.7	76.3
doctors (1961-1971)	70-80	20-30
nurses/ANMs (1971)	60	40
hospitals (1981)	73.9	26.1
dispensaries (1981)	20.2	69.8
hosp./disp. beds (1981)	83	17



proximate and not always very recent, *their overall picture of a grossly unequal and unjust distribution is unfortunately all too correct. India's health system has grown in total disregard of the country's needs! Less than one-fourth of the population gets about three-fourths of everything! Comparatively speaking, the urban population thus enjoys 8 or 9 times more facilities...*

34. On this, see HS 1981, p. 55. There was about 8,400 population per ANM in 1979-80.

35. On this, see Bannerjee (p. 14) and Bang/Patel (p. 26).

36. Compiled and calculated from HS 1981, pp. 100 & 105; R. Jeffery, in EPW 1976, p. 504, and 1978, p. 105; R. Bang, in Bang/Patel, p. 76; and the information contained in the next paragraphs. Most of these figures are evidently approximate.

A few additional remarks may be helpful. Various estimates place 67 to 80% of the doctors in urban areas, and only 20 to 33% in rural areas... *The doctor population ratio moreover greatly varies from region to region*: 1 doctor per 1,300 population in Delhi to 1:6068 in Meghalaya and 1:40,000 in remote areas. The Health Minister even admitted that several rural areas have no doctor within a 50-mile distance and for a one lakh population.[37] According to Jeffery, the doctors were thus employed in 1978: public sector (50,000), private sector (9,000), self-employed (82,000), abroad (21,000), remainder (38,000)—the last category includes the unemployed, underemployed and economically inactive. *Only 25-30% of the doctors are thus in the public sector! And India, the world's largest exporter of doctors, has lost about $150 mn by the brain drain!*[38] According to new health care models, which make greater use of the ISMs and of semi- and para-professionals, *India has already, or will soon have, too many doctors.*[39] *In fact, urban- and curative-oriented doctors are of a limited usefulness in villages...*[40] *And the same holds good for nurses and ANMs who are brought up and trained in cities...*

It is evidently more difficult to specify the exact urban/rural distribution of the budget. We have already highlighted the relatively small expenses on PHCs and the huge disparity between expenditures on urban and rural water supply/sanitation with its tragic consequences for rural areas.[41] The Health Ministry acknowledged in the mid-1960s that most of the investments of our FYPs go for the building of sophisticated hospitals and the training of doctors, both of which hardly serve our rural popula-

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37. On this, see PBHS 1979, p. 52; "Manorama... 1981", p. 489; and "The Indian Journal of Medical Education", Jan. —April 1982, p. 4.

38. On these questions, see Jeffery, in EPW 1976, pp. 502-7; IE, June 2, 1976; and "Times of India", August 8, 1981. According to UNCTAD studies, each emigrant doctor means a loss of Rs. 3 lakhs to India. The cost of training a doctor was about Rs. 1 lakh in the mid-1970s...

39. On this, see for example "Health For All", pp. 161-2, and "Alternative Approaches...", pp. 193-4.

40. This point is time and again emphasised in "Alternative Approaches...", pp. 95, 102-5, 111-2, 114 & 121.

41. See above, p. 19.

tion; 3/4th of the State budget for health is also spent on the running expenses of more or less elitist institutions, while only 1/4th is directly made use of for the real needs of the masses.[42]

Government reports and "Health For All" contain several other general statements to the effect that *the bulk of the expenditure goes for urban and curative services.* According to Antia, *not more than Rs. 3-4 per person were annually spent around 1980 on the PHC downward,*[43] *that is about 25% of the total expenditure.* A Committee appointed by the Govt. of Maharashtra even "reported that out of the total health expenditure of Rs. 156 mn by the Govt. in the state, 80% was spent on 3 cities—Bombay, Pune and Nagpur; 6.2% was spent on the district towns; 4.5% on the villages and 0.5% on the tribal areas. Per-capita per year health expenditure by the Govt. was in Bombay 14.60 Rs., in Pune 12.17 Rs., in Nagpur 8.09 Rs., and that in the villages was the colossal sum of 13 paise!"[44] *Whatever may be the exact urban/rural distribution, which we put at 75/25% in Table II, the urban orientation of the policy-makers is very clear!*

The following information enables us to realise still better the dismal state of rural health services. In early 1981, rural areas had as much as 40,480 *pop. per hosp./disp.,* 6,217 *pop. per hosp./disp. bed,* 94,277 *per PHC and* 10,189 *per PHSC.*[45] *The manpower and financial situation is also extremely pathetic.* According to Vaid, the doctor-population ratio in the villages is 1: 17,000. Most of the newly established PHSCs (cf. Table 3) are without essential staff: "The State-wise position of centres without staff is: Andhra 862; Bihar 1364; Gujarat 120; Madhya Pradesh 1020; Orissa 964; Tamil Nadu 936; West Bengal 1248

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42. On this, see the "Report of the Study Group on Hospitals", Govt. of India, 1968, pp. 18-20. According to the World Bank Paper, the Indian Government spent only 37% of its 1965-66 health budget on public health or prevention, and 55.5% on curative care ("Health", p. 76.)

43. in EPW 1981, p. 1364.

44. Given in Bang/Patel, p. 167.

45. Calculated from HS 1981, pp. 55, 100, 105 & 112. *This is a far cry from the long-term targets, which are respectively* 1000 *population per hosp./disp. bed* (Mudaliar Report), 30,000/20,000 per PHC and 5,000/3,000 per PHSC (FYP VI for 2000 AD) (cf. above, p. 27).

and Maharashtra 656. The same is true of most of the (3213) subsidiary centres." About 50% of the UP PHCs are also in rented buildings and without amenities, and 200 of them are without medical officers.[46] *Various surveys moreover reveal that rural health centres have a generally poor image and remain underutilised.*[47] *Even a dedicated, serviceable and culturally well-integrated personnel would find it difficult to have a wide coverage and to be efficient under such circumstances and constraints!*

It is estimated and often stated that 50 to 80% of the world population have little or no access to modern health care.[48] *Available studies lead to three conclusions for our country: (i) the use of health services is closely connected with their proximity; (ii) the coverage of modern services remains extremely low; and (iii) a much greater percentage of sicknesses is attended by indigenous* and *folk practitioners.* One survey for example revealed that the percentage of outpatient attendance to rural dispensaries halves every half-mile, and another one that 60% of the patients of a PHC came from within a mile. Two rural studies made in the North showed that only 7 and 10% of the illnesses reach the health centres and that indigenous practitioners are consulted three times more often than allopathic professionals. Several recent studies have also brought out that about 5% of the population receives help from the PHC, 10% from registered practitioners, and the rest from unlicenced indigenous practitioners. The striking findings of the extensive survey of the Chiraigaon Block, Varanasi, confirm these results (Table 12).[49]

It can therefore be stated that *about 70 to 80% of India's people "do not have access to even the most elementary (modern) health care services."*[50] On the basis of the available evidence,

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46. in IE, July 30, 1983, p. 8. For other details on rural centres, see above, pp. 19-22; "Health Services...", pp. 17-8; Park & Park, pp. 689-90; and V. Ramprasad, in MFCB 77, pp. 6-7.

47. On this, see for example Banerji (in EPW 1973, pp. 2261-8, and "Poverty...", especially pp. 300-6); "Alternative Approaches..." (pp. 165-6 & 179-80); and MFCB 81, pp. 4-5.

48. See above, pp. 31-4. On this, see also the World Bank Paper, "Health", pp. 35-8, and King, "Medical Care...", op. cit., pp. 2:5-2:7.

49. For details on these studies, see the World Bank Paper, pp. 35 & 38, and "Alternative Approaches...", pp. 165-6 & 205-6.

TABLE 12[51]

Health Centre Outreach
(including sub-centres)

	%
Population never using PHC services	77
Proportion of Morbidities attended	10.4
Patients beyond two miles	14.5
Female Patients beyond two miles	8.4
Proportion of infants covered by MCH Programmes	20
Visits per infant (Yearly)	1.2
Coverage of Infants beyond two miles	9
Coverage of antenatal cases beyond two miles	7.3
Deliveries beyond two miles	8
Proportion of Female Patients in O.P.D.	33.7

Kodiar, Marvah and Udupa conclude that about 20% of the sickness episodes are taken care of in family circles, while 40, 24 and 16% are respectively treated by folk practioners, indigenous practitioners—4.5% trained, 19.4% untrained—, and modern allopathic practitioners.[52] The VIth FYP rightly asserted that *the modern health infra-structure "touches only a fraction of the rural population..."*[53] *And what a small fraction!*

No long conclusion is needed. We have clearly delineated the main achievements and weaknesses of India's health situation and system. *The disturbing facts and scandalous inequalities we have come across speak for themselves and constitute the most serious indictment of our post-Independence policies.* In the next chapter, we shall analyse the root-causes of our failures and understand our health system in relation to the overall functioning of Indian society.

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50. Naik & Banerji, in Naik, pp. 12 & 37.

51. Given in "Alternative Approaches...", p. 205.

52. in "Alternative Approaches...", pp. 204 & 209-10. According to the authors, each Block possesses about 2 doctors and 40-50 paramedicals in the formal health system, 4-5 modern practitioners and 30-40 indigenous ones in the informal system, and 600 folk practitioners in the folk system (pp. 206-9).

53. p. 367.

4. Towards a Proper Analysis

India had entered the path of modern development and planning with great hopes and expectations after Independence, but the country is now facing a serious crisis. It has indeed become evident that the promises have been belied and that the majority of our people have not reaped the expected benefits.[1] The third chapter has illustrated how true this is with regard to health. India's population continues to grow at an alarming rate and the health conditions of the masses remain distressingly low. Widespread poverty, malnutrition and ignorance, insufficient and/or unsafe water supply, miserable sanitation and housing, and many other evils still plague the countryside. Our health services are manifestedly inadequate and ineffective, especially in rural areas, and fail to cover 70 to 80% of our population. Inequalities in health standards and services are no less—if not more—glaring and scandalous than in the past. *The question is therefore fundamental and inescapable: what has gone wrong? How to explain, indeed, the failures of our policies? What are the root causes of this intolerable and unjust health situation and system?*

What Went Wrong?

The previous chapters have mentioned *the typical answer of recent Government documents and experts' Committees. Put in a nutshell, it reads as follows: "The adopted priorities were wrong. The chosen model was wrong.* This is the source of our failures." Various aspects of this explanation are stressed, but the basic content is identical.

It is for example sometimes deplored that social consumption and/or health were given a low priority in the Plans. The emphasis on the establishment of curative centres and super-specialities and on the training of allopathic health professionals, and the neglect of preventive medicine and rural areas, are more

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1. Fernandes well describes this growing crisis of confidence (pp. xiii-xvi).

frequently and seriously criticized. The urban and elitist character of the health services and the prevailing inequalities also come under heavy fire. The priorities of the FYPs are thus clearly blamed for the failures. Though very explicit in "Health For All", criticisms of the FYPs' investment pattern often remain rather indirect.[2]

The prevalent model is considered irrelevant for several interconnected reasons. Instead of answering the specific problems, needs and aspirations of Indians, being attuned to their customs and traditions, and taking into account their local medicines and practitioners, this Western system mainly responds to the socio-economic conditions and disease patterns of developed countries, neglects the ISMs, and uses highly specialised personnel, sophisticated technology and costly drugs. By their training, life-style, ideas, attitudes and values, the modern health professionals are most often alienated from the rural masses and the low-class city-dwellers who, in turn, feel out of place in the modern health care environment. Medical education and research are also hardly suited to the needs and problems of a Third World country like ours.

The Western model moreover fails to pay enough attention to socio-economic, political and cultural factors, and thus adopts a sectoral rather than integral approach.[3] The key issues of food, water, sanitation, housing—and employment,. wages, land distribution, human rights, people's organisations, etc.— fall into the background or are even forgotten. The holistic concept of

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2. For this paragraph, see for example the passages quoted above, pp. 23-8 & 35-8.

3. Newell interestingly comments: "It is difficult to work out the reasons why members of the health services have tried to separate 'health concerns' from other parts of the (total rural hopelessness) complex. Is it because we do not understand the problem or feel incompetent or powerless to influence the main issues, or because we want to 'control' our own field? Whatever the reason, it is clearly not because we have scientific 'evidence' that it is the most effective or the cheapest way or that it is what the people want. On the contrary, we have studies demonstrating that *many of the 'causes' of common health problems derive from parts of society itself and that a strict health sectoral approach is ineffective, other actions outside the field of health perhaps having greater health effects than strictly health interventions*" (pp. x-xi).

health disappears. The social, preventive and promotive aspects are played down, while the individualistic, curative and clinical are overemphasised. Individuals are treated, not communities. And, in this curative approach, there is not even a well-organised referral system. Rather than providing basic health facilities to all citizens, irrespective of their wealth, *this model gives specialised care to a few rich. It has recourse to an "expensive technology to treat ever smaller numbers of people, at ever higher costs." And this approach "has been at the cost of providing comprehensive PHCA services to the entire population", for "the services available to the few consume most of the health budget and deprive the majority of services of any kind".*[4]

In spite of some lip-service and patchwork, health education and community organisation are either inexistent or negligible in this model. The services are centralised, bureaucratic, top-down, and the decision-making process is controlled by health administrators and professionals. Even when villages are "reached" and "covered", the rural community is not really involved. Far from fostering people's participation and growth and being community-supportive, this model creates more dependency and becomes community-oppressive.[5] Financial self-sufficiency and all-round self-reliance are not promoted. LHWs and other paraprofessionals are not encouraged to take up important responsibilities. Often, there is no proper supervision and no "health team" worth this name, and even the health work lacks integration and coordination.

Health experts and policy-makers thus list many things that "went wrong": priorities, investment patterns, model, approaches, strategies, assumptions, etc. The emphasis evidently varies from report to report, but the same basic message is repeated: our health model and priorities were not properly chosen. Though most educated persons and perhaps even health professionals are not yet aware of the fact, these major failures are widely acknowledged by experts.

A more radical question must however be asked to under-

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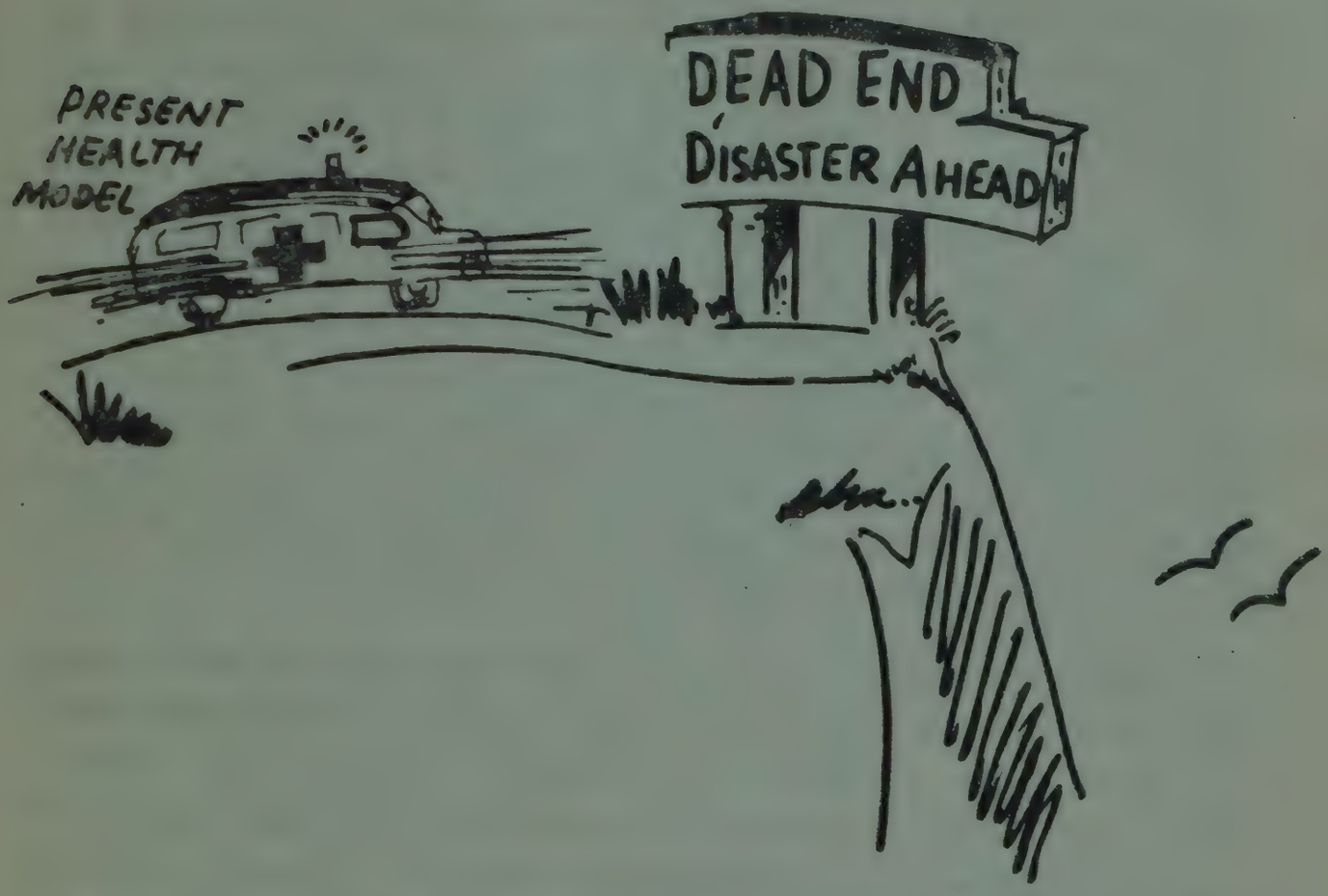
4. Respectively quoted from Jeffery (in EPW 1976, p. 502), "Statement..." (para. 4.2), and Illich.

5. On this, see for example Werner, "The Village...", and "Helping...", Front 1-3 (cf. below, pp. 115-6).



stand the situation better: why did these failures occur? Yes, why did the Government fail to eradicate poverty and curb inequalities? Why did our health services evolve as they did? How to explain that wrong priorities and policies were established? Why was this unsuited model chosen... and kept for so long? Why did the country find it so difficult to match theory, planning, and implementation? Why this toning down and these delays with regard to alternative models? Why is it that funds for urban and curative services have not been curtailed in the Vth and VIth FYPs and that the investment pattern has not been radically changed? In short, why is it that this specific health care system, with all its characteristics and consequences, has developed in India? *Such questions must be answered if we want different policies not only to be talked about but also implemented.*

Why These Failures?

Many health professionals and planners may sincerely, but also naively, reply: "We did our very best. We were convinced about the superiority of modern medicine. We wanted competence and excellence in the medical personnel and first-class medicine for our people. We therefore thought of specialists and full-fledged doctors and nurses, and of first-rate research centres,

medical colleges and hospitals. And we dreamt of extending the health services and providing good facilities to rural areas through dispensaries and PHCs. We did not see any alternative... We took all this for granted..." *Many people may agree and explain the wrong policies of the past by a lack of experience and knowledge.* Now that the mistakes have been realised, it is hoped and assumed that the alternative models will be implemented.... To this way of thinking, any further questioning of Government policies may appear unnecessary and biased. Deeper criticisms may sound like unfair attacks against certain political parties and personalities. And this ideologisation and politicisation of the health problem may be resented.

Such explanations of the past and hopes for the future may often be expressed in good faith. *But is the issue so simple? More and more social thinkers and scientists recognise that India's health priorities and investments were very predictable and that it is very difficult to transform them radically. Powerful societal forces indeed shape the health system and resist its restructuring.* These forces are at work within us and around us, whether we are conscious of them or not—in fact, especially if we are not. As Naik points out, the professed goals of our Constitution commit us to raise substantially the standards of living of the masses and their health conditions, and even "to create a new social order based on freedom, equality, justice, and dignity of the individual." "But the achievement of these goals is not an easy thing and it is also not in our immediate self-interest to do so. We, therefore, adopt hidden and implied goals of pursuing our own class interest. This is understandable (but not excusable) because a ruling class rules, first and foremost, for its own benefit and only incidentally for that of others. Thus develops a dichotomy wherein we talk of serving the masses of the people..., while in reality we are more busy than ever in aggrandizing things for the benefit of our own classes."[6] *It is therefore necessary to analyse the functioning of the health system within the broader societal framework in view of unmasking these more or less hidden forces and vested interests.*[7]

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6. p. 7.
7. On this, see for example Kaithathara (in Volken, "Learning...", pp. 65-6, and "Social Action" 1981, pp. 352-3) and Carvajal (in Rifkin, pp. 17-26).

A health care system functions within the broader socio-economic, political and cultural—or ideological—systems. Being only a sub-system, it heavily depends upon, and in turn supports and strengthens, the other systems. Though enjoying a limited autonomy and freedom of operation, the health care system basically corresponds to, and reflects, what happens in the overall society. It is therefore normal that the health policies of the Indian Government betray the same class bias as the economic policies, for they were made by the same political leadership under the same economic pressures and legitimising ideologies.[8] *Let us now consider the interrelationships of our health system with these broader structures and reflect in depth on the role of vested interests. This will lead us to a much better understanding of our failures.*

Health & Society

To state that *health is intimately connected with economics* has become a truism. "The synergism between poverty, malnutrition, infection and increased morbidity and mortality is now well-established."[9] Poverty often causes sickness and determines the disease patterns—hence the expression "diseases of poverty". The poor can even, to some extent, become biologically adapted to sub-standard conditions of life and consider their sicknesses as "normal".[10] Access to the health system is moreover deeply conditioned by one's possessions and income. Our reflection on vested interests will also show that health priorities and models are basically shaped by the socio-economic system.

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8. On the class character of "The Independence Movement", the "Post-Independence Economic Policies" and the "Indian Political Parties and Ideologies", see these titles in the CSA series. Carvajal thus speaks of the Philippines: "The health care system... functions as an element within the macro-social system and has its role defined by the structure of that system." "The health care system is determined by the economic system, which explains its being urban-centered and oriented towards curative-intervention techniques. It is further dominated by both the political (hence, doctor-centered) and the cultural (hence, western drugs and technology) system." (in Rifkin, pp. 18 & 23). The same could be said of India.
9. "Health For All", p. 18. This report succintly sums up this question (pp. 17-9).
10. On this, see for example Banerji, "Poverty...", pp. 220-1.

One must however proceed further and realise that poverty and inequalities are structurally two sides of the same coin. *The underlying cause of disease and death among the poor is this "cruelly unequal distribution: of wealth, of land, of educational opportunity, of political representation, and of basic human rights." Inequity is the "primary disease." The "health of the people is far more influenced by politics and power groups, by distribution of land and wealth, than it is by treatment or prevention of disease."*[11]

Poverty and inequalities in the health field have their roots in our unjust socio-economic system and reflect our dualist society. In fact, our health system even strengthens this inequitous social order. For it helps the affluent class to deal effectively with its few health problems, while it weakens the poor in their frequent health crises. In serious cases and emergencies, the latter have indeed to pay costly medicines and fees, borrow money, ask for favours, and become indebted— both economically and politically. The health system thus contributes to increase poverty, inequalities and dependency. In its way, it serves "as a weapon to control and exploit the poor."[12]

The health situation and system of a country is moreover deeply affected by politics, for "the ultimate decisions in health are essentially political."[13] "Political forces play a dominant role in the shaping of the health services of a community, through decisions on resource allocation, manpower policy, choice of technology, ... the degree to which the health services are to be available and accessible to the population," and the formation of alternatives.[14] A national decision for radical societal change is most crucial for health.[15] There is also the key issue of parti-

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11. Werner, in IA 127-8, p. 29, and in Bang/Patel, pp. 157-8; author's emphasis in the last sentence.

12. Banerji, "Poverty", pp. 221-2.

13. Naik, p. 26. On health and politics, see for example Banerji (in Bang/Patel, pp. 133-49; Naik, pp. 31-47; and "Political Economy..."), and Werner (in "Helping...", Front 7-12; MFCB 69, pp. 1-4 & 8; and "HOW" 1982 no. 3, pp. 15-8). Werner gives a simple and moving account of his discovery of the impact of politics on health.

14. Banerji, in Naik, 31, 33 & 45-6. On this, see also Bannerjee, pp. 3-4.

cipation. *"A political system where there is a commitment to extend the process of democratization and involve the entire population in decision-making" constitutes a pre-requisite for real people's participation in health services and the setting up of a meaningful alternative.*[16]

This is why "Health For All" highlights the need for "a democratic, decentralised, and participatory system of government", and Werner stresses that "the politico-economic structure of the country must necessarily influence the extent to which its rural health programme is community supportive or not." Experience teaches that health standards improve and that inequalities in health status tend to be reduced wherever this democratic process takes place.[17] Our inegalitarian and centralized health model has not fallen from the sky. It is rather political decisions and vested interests which have created it. The health system, in turn, supports the socio-economic and political status quo by its unjust and oppressive features.

The health sub-culture of a nation is greatly influenced by, and to some extent influencing, its overall culture. This sub-culture comprises the perceptions and meanings of health problems, the responses to various services and practitioners, and the concrete health practices.[18] In short, it includes the whole complex of customs, ideas, attitudes and values, with regard to health, disease, medicines, and health institutions and practitioners. In this context, Bannerjee points out that Western medicine is based on an individualistic perception of human beings—the Cartesian model of the body and the germ theory of illness—, a clinical/

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15. On this, see Newell, pp. 198-9. Banerji (in Naik, pp. 31-2) and K.S. Sanjivi (in "Alternative Approaches...", pp. 158-9) agree.

16. Banerji, in Naik, pp. 33-5 & 37-8. Banerji adds that "such democratisation is not possible in a stratified society where a small privileged class controls the social and economic life of vast masses of people."

17. See above, pp. 37 & 39; Werner, in Bang/Patel, p. 158; and "Health For All", pp. 19-20.

18. On this concept, see Banerji, in EPW 1974, p. 1333, and in "Poverty...", pp. vii, 2 & 208. The author remarks: "As it is a sub-culture, health culture is affected by changes in the overall culture of a community, which are mediated by various ecological, social, demographic, economic and political forces" (p. vii).

curative approach to health, and the transformation of health care into a "commodity" by capitalism. Health care has thus become individualized and purchasable.[19] This capitalist (colonial) health system has "profoundly influenced almost all aspects of medical education in India—in shaping the institutions, in developing the course content and, perhaps most important of all, shaping the value system and the social outlook of the Indian physicians."[20]

Sheila Zurbrigg thus highlights three basic assumptions of the medical profession: " (i) *control over health care services*—that doctors understand best society's health needs and should therefore control to a major extent the shaping of healh services; (ii) *individual versus societal responsibility*—that a doctor's *primary* responsibility lies at the level of the individual... The implication is that the profession, and the individuals within it, are above, or excused from, broader considerations of societal accountability; (iii) *medicine as private enterprise*—that the profession will defend the absolute *right* to use its skills in a private as opposed to social context." These assumptions imply that the profession's needs take priority over the people's.[21] Jeffery moreover shows how much doctors are influenced by their attempts to "keep up with the West", and to be "scientific", "modern" and "autonomous".[22]

The health culture supports the overall culture which justifies the present socio-economic and political systems: "The health-care system supports the dominating, elitist and foreign culture of the upper classes by promoting the myth that good health means better western medicines and medical treatment; that there is a positive correlation between medical intervention and the health and well-being of the people, and that western drugs and techniques of health care are superior. In short, the health-care system promotes a concept of health care that is beneficial towards its economic, and protective of its political aspects. It conveys the message that there is nothing wrong with

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19. pp. 4-5 & 6.
20. Banerji, in EPW 1974, p. 1334.
21. ch. IV; author's emphasis. This passage from a forthcoming book is yet to be finalised.
22. in EPW 1976, pp. 502-7, and 1978, pp. 101-13.

the social structure of the country. For health development, all that is needed is more professional medical personnel, more sophisticated research, more (western) drugs and techniques, and for the dominated what is needed is more discipline, more industry and more thrift."[23]

The health system has therefore to be "demystified, deprofessionalized, debureaucratized, and decommercialized to provide better services to the masses."[24] It is not only the health culture of the masses that must be transformed, but also and mainly that of the hospitals, the medical colleges, and the health professionals!

Health & Vested Interests

Before concluding, let us specify how *vested interests have shaped, and perpetuate, our present health care system.*[25] In our capitalist society, the mechanism of effective demand inexorably orients the supply system towards the service of the privileged few. "This primary factor determines in many ways the very nature of the available health services. The demand of the well-to-do is obviously for highly specialised curative care, whereas the need of the community at large in rather for preventive and simple curative care. In this way, the type and the distribution of health services is largely determined by the elite, i.e., the high income groups. The type of medical personnel required needs very costly training, and equally costly is the equipment of hospitals, health centres and clinics. Such an expensive health care system remains, of necessity, inaccessible to the majority who are poor." *The structure of effective demand thus deeply conditions the nature and distribution of the health services and of their various institutions, technologies, professionals and medicines. It concretely decides whose interests all these will serve.*[26]

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23. Carvajal, in Rifkin, pp. 22-3.
24. Banerji, in Naik, p. 38.
25. For this section, see especially Zurbrigg, ch. IV, "Forces Shaping The Health Care System." This chapter deals with professional, commercial and class interests, and the economic and political order.
26. Kaithathara, in "Social Action" 1981, pp. 351-2, and in Volken, "Moving Closer...", p. 61.

The upper and middle castes/classes moreover directly influence the making and implementation of policies by their political contacts and organisations, and even by their briberies. In fact, they usually provide the political leadership! Politicians, in turn, actively promote the urban and curative orientation of the health services to meet their own needs and those of their class. For them, it is but natural that these services be of a greater quantity and better quality at the centre, the cities, than at the periphery, the villages—which comprise almost 80% of the population! It is also the same classes which benefit from the important subsidies granted to medical education ...[27] On the other hand, *politicians instinctively avoid challenging the basic "private-enterprise" assumptions of the doctors and the drug industries,* for this would potentially bring into question the very structuring of society and pose a comprehensive threat to their class interests and powers. The power structure of Indian society is thus at work, in many ways, to divert the development resources to the privileged classes. *In health as in other fields, "those who possess the power of wealth, social status, political influence and knowledge, control the lives of others."*[28]

Within this broad capitalist framework, the vested interests of health professionals also militate against the common good. Many instances can be given. One of the biggest obstacles to "health by the people" is the unwillingness of health professionals and authorities to let their control go. This is often experienced in the running of PHCs and the day-to-day working of health projects.[29] In India, the allopathic health professionals and their organisations/institutions often oppose the ISMs, the use of various CHWs and semi- and para-professionals, the reorientation of medical education, etc.[30] They react, or would react,

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27. On this, see Patel, pp. 157-8.
28. Kaithathara, in "Social Action" 1981, p. 352. For details, see Naik, pp. 11-2, and "Health For All", pp. 18 & 19-20. On the impact of power structures on development processes, see for example Fernandes, pp. xiv-xxiv.
29. On this, see for example Werner, in "Helping...", Front 2, and in Bang/Patel, pp. 152-3. "Health For All" expresses the need for redefining the role of doctors and seems to foresee the opposition of vested interests (pp. 83 & 90-1).
30. For examples, see Banerji (in Naik, pp. 36-7), Djurfeldt/Lindberg

sharply to any major reduction of resources for urban/ curative services, specialised centres, and medical education! And to any measures curtailing private practice and radically orienting doctors to the people's needs—for example by prolonged compulsory posting in rural areas! This is one of the main reasons why such decisions are not taken or implemented... *As a whole, the present system gives priority to the interests of health professionals over those of the masses and the medical profession acts as a conservative force that resists change. All this is not surprising, for health professionals share the basic assumptions of our class society.*[31]

Commercial vested interests are no less harmful.[32] The drug industry in India has increased its production from Rs 10 Cr in 1947 to Rs 1200 Cr in 1981, but its profit-making orientation has resulted in *the overproduction of non-essential (often costly) drugs for the rich and the shortage of essential drugs (which can be made available at a low cost) for the poor.* Its largely Western production pattern is irrelevant to the health needs of our developing country and can be termed drug colonialism. In

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("Pills Against Poverty". Oxford & IBH Publishing Co., Delhi. 1975, pp. 215-6), Naik (pp. 11-2 & 16-8), and especially Jeffery (in EPW 1976, pp. 502-7, and 1978, pp. 106-9). The resistance to the ban on private practice by Govt. doctors in AP is a recent case in point (MFCB 91, p. 8).

31. At a recent Bangladesh Conference on "People and Health", R. Sobhan asked: "In a society dominated by market forces, where all commodities are on sale at the highest price possible, how can one expect, without touching these forces, that the doctor should offer his or her service which itself is but a commodity, not at the highest return on his or her investment but where the services are most needed?" (reported in MFCB 89, p. 2).

32. Among the abundant literature on this subject, see for example Naik (pp. 19-21), "Health For All" (pp. 91-2 & 175-86), "Seminar" 1975 no 190, "Health For The Millions" 1981, no 2-3; A. R. Phadke, in Patel, pp. 81-7, and in MFCB 73-4, pp. 1-4 & 11; and EPW 1976, pp. 496-501. For details, see V. Coleman, "The Medicine Men", Arrow Books, 1977; T. Heller, "Poor Health, Rich Profits", Spokesman Books, 1977; I. Illich, "Medical Nemesis", Rupa & Co., India, 1975; C. Medawar, "Insult or Injury?", Indian Social Institute, Delhi, 1981; and the "Report of the Committee on Drugs and Pharmaceutical Industry", Hathi Committee, Govt. of India, 1975.

1976 for example, 25% of the production consisted of "vitamins, tonics, health restoratives and enzyme digestants mostly consumed by the relatively well-fed urban population", while "the production of INH for tuberculosis and of Dapsone for leprosy... (was) only one-third and one-fourth respectively of minimal requirement."[33]

Table 13 shows the 1978-79 production and import of bulk drugs and formulations. We still import about 40% of our re-

TABLE 13[34]

Bulk Drugs and Formulations (1978-79)

Sector	Bulk Drugs		Formulations	
	Rs (mn)	%	Rs (mn)	%
Public	539	14.6	600	5.7
Indian private	825	22.3	3,400	32.4
Foreign	616	16.7	4,600	43.8
Small-scale	220	5.9	1,900	18.1
Imports	1,500	40.5	—	—
Total	3,700	100	10.500	100

quirement of bulk drugs and are far from self-sufficiency in this respect! On the other hand, *the market is flooded with more than* 30,000 *formulations... And almost all of them are non-essential, and many are wasteful and even harmful!* WHO for example lists about 20 essential and 45 complementary drugs. In India, the 1975 Hathi Report proposed 116 generic drugs, while the "Health For All" document suggested 18 essential drugs for use at the community level. In spite of Hathi's recommendation, companies are also still allowed by the Government to market and sell *brand name drugs* at a price that is often four to five times higher than that of generic name drugs.[35] *As a consequence*

33. "Health For All", p. 178.

34. Adapted from "Health For All", p. 180.

35. For the last sentences, see "Health For the Millions", op. cit., pp. 11-6; U.N. Jajoo, in MFCB 80 (pp. 1-4) and 81 (pp. 1-3 & 7); Phadke in Patel, p. 84; and S. Vaid, "An Exercise in Futility", in IE, 19 June 1983, p. 6.

of all this, the poor do not get the medicines they need at a price they can avord. And the inequalities are so striking and unjust: 20% of the population for example bought about 80% of the drugs in 1973...[36] *Commercial interests thus clearly prevail over people's interests!*

Table 13 moreover shows that *foreign companies account for more than 40% of the very profitable formulation market. The industry is also highly monopolised.* In 1973 for instance, 110 manufacturing companies—less than 5% of the 2300 firms! —produced 80% of the drugs. Among them, 28 were foreign-owned: 1.2% of the campanies thus cornered about 40% of the production! And 9 of the 12 firms having a turnover of Rs 4 Cr and above were multinationals![37] *The profits of drug companies, especially multinationals, are also enormous.* "The American multinational, Smith, Kline & French (SK & F) which invested only 5,000 pounds (about Rs. 75,000) in the year 1961 has at present an annual turnover of more than Rs 14 Cr in the country, and another Rs 3 Cr in exports. The gross profit of SK & F for the year 1976-77 was approximately Rs 3 Cr." In the space of four years (1974-77), Glaxo Laboratories India Ltd. and Pfizer Ltd. respectively made Rs 19.2 and 23.8 Cr in profit before tax. And "a case study of 42 foreign drug companies showed that during the period 1968-69 to 1977-78, these companies repatriated Rs 45.11 Cr out of India in the form of profits, dividends, royalties, office expenses, etc."[38]

Drug companies moreover build up *massive advertising campaigns,* which overstate the advantages of their products, hide their dangerous side-effects, and deeply influence both the prescribing doctors and the consuming public. In this way, they destroy excellent traditions (breast-feeding for example), create costly—and sometimes harmful—needs (baby foods, tonics, vitamins, pain-killers, etc.), exaggerate and mystify the importance of doctors and drugs, and increase dependency. They also resort to several malpractices such as overpricing, bribery, dumping of useless or harmful drugs, dangerous experimentation on human

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36. Phadke, in Patel, p. 82.

37. ibid., pp. 82-4.

38. Quoted from A. Mishra (in "Sunday", 15-21 Aug. 1982, p. 34) and Phadke (in MFCB 73-4, p. 4).

beings, etc. *The 1978 National Drug Policy basically failed to make any significant impact*: multinationals continue to prosper; essential needs are not met; brand names are used and dangerous drugs marketed; prices steadily rise; misleading advertisements invade us everywhere; etc.[39] In short, "the *pharmaceutical industry has become a vested interest in ill-health. It has set up a tremendous propaganda apparatus and uses the medical men particularly as its salesmen. It is this vested interest which leads to proliferation of drugs (where none is needed), to increasing costs of drugs, to over-medication, and to distortion of values.*"[40]

Our health care system was born under British colonial rule and grew with Indian capitalism. Powerful class, commercial and professional interests therefore profoundly shaped everyone of its features. And the same interests naturally oppose, or at least try to delay and dilute, its radical restructuring. Naik can therefore conclude: "The existing infrastructure and professional groups have become a big vested interest... The vested interests of the well-to-do and urban groups who hold real reins of power would obviously be the biggest hurdle" to change.[41] And "Health For All" adds: "A good deal of damage has already been done by the wrong prescribing habits of the doctors and the vested interest propaganda of drug producers so that the health care system is highly medicalized already and tending to be more so." We are dangerously close to the point at which "the over-production of drugs and doctors creates a vested interest in the continuance or expansion of ill-health".[42] This is to put it mildly, for this point has already been crossed...

It is evident that *the poor of India would not have made the same decisions as the Government.* Never would they have for example chosen to allocate about 75% of the budget, personnel and hospital beds, for less than 25% of the population, the urban dwellers! Or to spend money on prestigious institu-

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39. For suggestions for the future, see "Health For All" and the Conclusions of the Drug Sub-Group at the "National Health Policy Seminar", April 1983, given in MFCB 91, pp. 6-7.

40. Naik, p. 20. According to Naik's understatement, these dangers have "begun to appear in our midst". They are very well present!

41. p. 25.

42. pp. 92 & 83, cf. also 179 & 185.

tions, sophisticated equipment and super-specialities ... experi-on food, water, housing and PHCA! *Such decisions ... erty neither the interests nor the views of the poor!* ...s

Why do the masses however accept our health system? W. don't they rise in protest against its injustice? To put it very frankly and simply, it is either because they are unaware of the extent and source of their exploitation, or because they are unorganised and therefore powerless. But, one may ask, why are they not more aware and organised? The key reason is inseparable from the forces and structures of exploitation and lies in their tragic poverty. Their constant struggle for survival indeed leaves little room for information and education-conscientisation, and makes them very vulnerable to the displeasure of the rich and the threat of unemployment. And the fear of direct repression still worsens their plight. Poverty thus renders the masses powerless to pressure for meaningful changes in the health system, and to confront the socio-economic and political forces that exploit them. *"This powerlessness, then, is the truer meaning of poverty for which ill-health and the lack of material possessions are but symptoms."*[43]

Conclusion

The previous analysis enables us to understand better the real failures of our health care system and their deep-rooted causes. *It is not only the health priorities, policies and model that went wrong, but the very process of socio-economic and political development, and the value system that animates it.* And these failures do not basically spring either from an unfortunate accident of history, or the ignorance and inexperience of health professionals and policy-makers, or the ill-will and conspiracy of the rich. They are rather "normal", "logical" and predictable in the present social set-up. For *the root cause of the problem lies in the capitalist nature of Indian society.* The health care system has indeed evolved as sub-systems usually do: it has been profoundly shaped by, and thus greatly reflects, the broader

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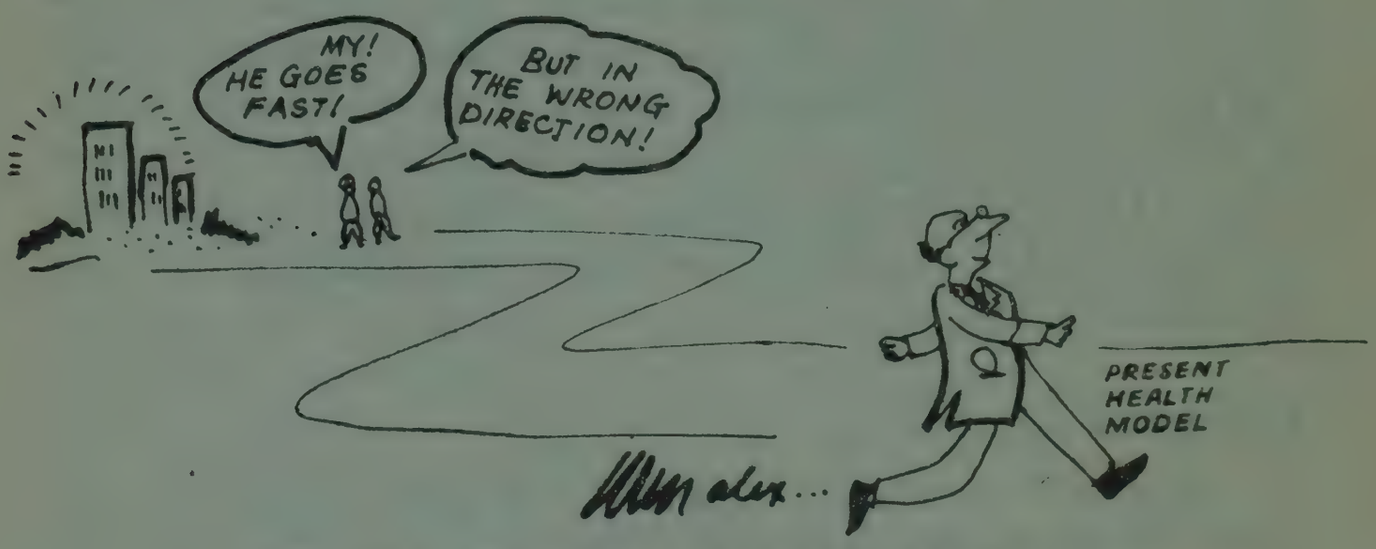
43. Zurbrigg, ch. V. *The author also remarks that the health of individual workers does not matter much within our economic system, for the country has a limitless reserve of unemployed and semi-employed. The capitalism of developing countries can thus tolerate much ill-health...*

socio-economic, political and cultural systems. *It is not at all surprising that a social system which fundamentally embodies the concepts of class and privilege and the values of individualism, ambition and competition, also accepts a skewed distribution of health services.* In such a society, industries and businesses as well as professionals and labourers, basically work for profit and this is what explains the vested interests of the drug companies and health professionals. Whether human beings are conscious of this or not, the major societal systems and the dominant class interests tend to shape all sub-systems and institutions. Hence, *the class character of the Indian health care system...*

Serving the Rich, Not the Poor!



The Class Character of the Health System...

This vision of history does not imply determinism. It does not absolve the rich, the powerful and the educated, from their responsibilities in developing a biased health care system. It only situates their responsibilities in the overall framework of the powerful forces that operate in society. Individuals and organisations can strengthen the exploitative societal structures and the working of class interests, either unconsciously or consciously. But they can also progressively free themselves from class interests and become agents of structural change. Far from being passive tools of history, they are thus responsible for their social ignorance or awareness, and for their negative or positive involvement. As in other fields of human behaviour, the degrees of responsibility evidently vary.

This is not however the whole story. Contradictions exist within capitalism and opposing forces are at work to build a

better society... and health care system. Through their experiences, the masses become gradually more aware of their poverty and exploitation and they discover the causes of their problems and sufferings. Liberal-minded intellectuals, socialist thinkers and community activists help to create awareness and articulate various demands. People's organisations and movements get more numerous and stronger. There is no doubt that *India has witnessed such a growth of social consciousness since Independence. This progress is also visible in the health field* and expresses itself in radical criticisms, a search for alternatives and some pressures for change. The system has so far responded by acknowledging its wrong orientation and pledging its commitment to "health for all by 2000". *This is surely a concession to the growing unrest,*[44] *and a victory for the poor. But the system, with all its vested interests, also powerfully resists change*: theoretical declarations go much beyond practical programmes and implementation; radical recommendations are toned down or distorted, and reforms introduced instead; vested interests are not challenged; major budget shifts are avoided; delays are multiplied; etc. *Yet, the agents of change continue the battle... There is a kind of ongoing class struggle in the health field. And all individuals and organisations, consciously or not, take a stand.*

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44. On this, see Banerji, in "Poverty...", pp. 222-4, and in "Political Economy...", pp. 13, 29-30 & 38-9.

5. Emerging Trends and Meaningful Experiences

The four previous chapters have made a historico-structural analysis of the Indian health care system. *This chapter takes stock of some meaningful experiences*—in both capitalist and socialist countries, and in the State of Kerala[1]—*and thus constitutes a stepping-stone for the discussion, in the next chapter, of concrete guidelines for health professionals and social activists.* Though a more comprehensive and detailed approach—including even a short history of world medicine[2]—would have been worthwhile, the scope of this study permits only to highlight some basic trends and issues and to pinpoint certain areas for further research. All the same, these *"emerging trends and meaningful experiences" enlighten our quest for relevant action and provide hope for the future.*

Developed Capitalist Countries

The striking evolution of developed capitalist countries with regard to health standards, problems, delivery systems, personnel and medicines, and their undeniably large impact on today's world, make it imperative to understand well what has happened. In our opinion, *four significant lessons* should be emphasised.

First, the basic progresses in health standards took place before the outstanding medical discoveries of our times were widely made use of and should therefore be attributed more to the overall betterment of nutrition and living conditions than to purely technical advances. "A definite improvement in the general health of the public became apparent in much of Europe and also in North America early during the second half of the nineteenth century. The improvement began therefore several decades before the medical discoveries of the scientific era could be con-

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1. The micro-level experiences of health projects are dealt with in the sixth chapter, for they are closely related to CHCA.
2. See for example Park & Park. pp. 1-11.

verted into practical policies... Improvements in the general nutritional state began when prosperity and greater facilities for the transportation of food made it possible for many people to afford at least one square meal a day; likewise, the mortality of many infections began to recede in a dramatic fashion in Western Europe and North America long before the demonstration of the germ theory of disease. No medical discovery made during recent decades can compare in practical importance with the introduction of social and economic decency in the life of the average man. The greatest advances in the health of the people were probably indirect results of better housing and working conditions, the general availability of soap, of linen for underclothing, of glass for windows, and the humanitarian concern for higher living standards."[3]

Second, public health and preventive medicine also greatly contributed to this health progress. In response to the growing evils of industrialisation and the frequent epidemics of cholera, public health was born around 1840 in England and 1850 in North America, and spread to most of Western Europe in the second half of the 19th century. This was the period of *the "great sanitary awakening": anti-filth crusade, clean water, and proper sewage systems and housing.* Preventive medicine began towards the end of the 18th century and introduced "the era of disease prevention by specific measures". Though we cannot describe here the developments of these two inter-related movements, their importance should be stressed.[4]

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3. R. Dubos, "Man Adapting", Yale University Press, New Haven, 1965, p. 365, quoted by Djurfeldt/Lindberg, op. cit., pp. 24-5. The author thus comments on our *historical ignorance*: "It was not until the end of the nineteenth century that the decrease in death rates from infectious diseases and malnutrition became obvious to everyone. For this reason, scientific medicine and the germ theory of disease in particular have been given the credit for the marked improvement in the general state of health. The present generation goes still further and now believes that the control of infectious and nutritional diseases dates from the widespread use of antibacterial drugs and from the availability of vitamins and processed foods. So short and parochial are our memories!" For details and references, see Dubos' book, and Zurbrigg, ch. IV.

4. Park & Park gives a short, but excellent, introduction to the history of public health, preventive medicine, social medicine and community health (pp. 5-10). Though the other terms are still

Third, the scientific and technological advances of modern medicine should be enthusiastically praised for their past achievements and acknowledged as indispensable for the future of humanity. Our book has clearly shown that capitalism has to a great extent individualised, commodified and commercialised health care, which is mainly considered as both a shrewd investment for production and a most profitable industry.[5] And that health colonialism has caused enormous injustices and sufferings in developing countries like India. These deserved criticisms should not however lead to a biased and absurd rejection of western medicine. Scientific medical discoveries are indeed universal. They should be genuinely adapted to every civilisation and thus become the real patrimony of all mankind. Accepted critically and integrated with the ISMs, they can greatly improve the quality of life. As we shall see, this is the basic policy of socialist countries...

Fourth, certain experiences of developed countries can help developing countries to tackle some of their health problems and to avoid disastrous mistakes. Let us single out a few key areas. As industrialisation steadily gains ground in Third World nations, their disease patterns and environmental problems will almost inevitably become more similar to those of rich nations. The public health and social welfare measures of some Western countries are also worth taking into account. As even their experiences in the socialisation of medicine...

The recent critiques of over-industrialisation and of the "medicalisation of life", and the new search for mutual self-care, are perhaps of still greater importance. Illich for example wrote: "The medical establishment has become a major threat to health. Dependence on professional health care affects all social relations... Medicine is about to become a prime target for political action that aims at an inversion of industrial society. Only people who have recovered the ability for mutual self-care... will be ready to limit the industrial mode of production in other major areas as well." There are "two modes in which the person relates

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used, community health is preferred nowadays.

5. For the characteristics of health care under capitalism, see for example Bannerjee (pp. 4-7) and Banerji ("Political Economy...", pp. 4-7).

and adapts to his environment: autonomous (i.e. self-governing) coping, and heteronomous (i.e. administered) maintenance and management... Only a political programme aimed at the limitation of professional medicine enables people to recover their powers for health care." "The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed amongst the total population... That society which can reduce professional intervention to the minimum will provide the best conditions for health."[6]

Socialist Countries

There are evidently wide differences in health standards and delivery systems within socialist countries, for example between Russia, the Eastern European countries, and the developing nations. Our search for meaningful experiences has however to be limited and will consider only *China, Cuba and North Vietnam*.[7] Table 14 gives a certain idea of the progress that has taken place in these countries—the statistics are approximate and vary from source to source, but the trends are clear—[8] and enables us to compare it to the evolution of India. *The health indicators of China, Cuba and North Vietnam, were formerly as pitiful as those of India. But what extraordinary achievements*

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6. "Medical Nemesis", op. cit., pp. 11-2 & 168-9. These few quotations sum up the theme of the book.

7. On China, see for example Paterson & Rifkin ("Health Care..."), V.W. Sidel & R. Sidel (in Newell, pp. 1-12), and S. Akhtar ("Health Care in the People's Republic of China. A Bibliography With Abstracts", IDRC, 1975, especially J.W. MacLeod's introduction, pp. 8-12); on Cuba, V. Navarro ("Health..."), A.F.T. Fernandez (in Newell, pp. 13-29), and the article of S. Conover, S. Donovan and E. Susser (in MFCB 68, pp. 1 & 4-6); and on Vietnam, the book of J.K. McMichael (ed). Abundant bibliographies are given in these references.

8. Compiled from Sidel (pp. 1 & 26), "Health" (World Bank, pp. 72-3), HS 1982 (p. 1), McMichael (pp. 69-70 & 218), "Statement..." (p. 18), "1982 World's Children Data Sheet", op. cit. *The World Bank gives 18 for IMR in 1970-75, but we have taken the data from the "1982 World Data Sheet". The death rate of 10.2 is for 1970-75. **We could not find any earlier reliable data. ***The data on North Vietnam come only from McMichael's book, for the other writers we could consult do not distinguish between North and South Vietnam.

TABLE 148

Progress in Health Standards

		IMR	Death Rate	Life expectancy
China*	1949	± 200	25	—
	1982	45	10.2	65
Cuba**	1970-75	28	5.9	72.3
North-Vietnam***	1945	300-400	26	32
	1968	33.7	7.6	—
India	1951	146	27.4	32.4
	1981	127	12.4	52
(Target)	2000	60	9	64

in comparison! In fact, these countries have already fulfilled almost all the targets that India hopes to reach by 2000 AD! And they are closer to the health indicators of developed countries than to those of developing countries!

The China Study Group can therefore affirm: "The last quarter century has seen *a radical change in the health conditions of the Chinese people.* A redefinition of the basic approach to health care has been worked out. Problems hitherto considered insuperable in a poor country have been solved. A foundation has been laid for continuing improvement... *The Chinese have been able to develop a system of health care delivery that is more equitable, more rapidly expanding and lower in cost than would have been thought possible.* They have also, it seems, been able to encourage a good deal of research in *materia medica*... This they have done without major reliance on either the resources or the methods of other countries."[9] Nearly all reports

9. Paterson & Rifkin, p. 123. MacLeod basically agrees and lists seven indisputable accomplishments of the Chinese system (in Akhtar, p. 9).

on the Chinese experience in health care agree with such a positive assessment...

With regard to Cuba, it was rightly said that, "in education and public health, no country in Latin America has carried out such ambitious and nationally comprehensive programmes." In spite of heavy odds, Cuba has succeeded to build "a universal and comprehensive health system". "Its successes are legion: infectious disease is virtually eliminated, infant mortality is the lowest in Latin America, psychiatric care is profoundly humane." *This "revolutionary health-care system (is) of a quality unequalled anywhere else in Latin America."* And some experts also claim that *"the development of the Health Services and the elimination of epidemics in North Vietnam is one of the outstanding success stories of the century".*[10]

But what policies brought about these striking achievements? The First National Health Conference of China enounced *four fundamental principles of health work in 1950.* (1) Health care must serve the people's needs and "reach the general population, with a new stress on rural areas where most of the people live."* (2) "Preventive medicine should be put first—that is, where resources were limited, preventive medicine was to take precedence over therapeutic medicine." (3) "Chinese traditional medicine should be integrated with Western scientific medicine—that is, instead of competing, the practitioners of the two types of medical care should learn from each other." This involves "the use of a broad range of auxiliaries and the retraining and integration of traditional practitioners into the system."* (4) "Health work should be conducted with mass participation —that is, everyone in the society was to be encouraged to play an organized role in the protection of his own health and that of his neighbours." "Health care is an integral part of overall social, political and economic development"* and "health campaigns should be coordinated with other mass campaigns."*[11]

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10. respectively taken from J. Levinson and J. de Onis, quoted by Navarro, p. 1; Conover..., op. cit., pp. 6 & 1; and McMichael, p. 13.

11. The quotations with an asterisk are taken from Paterson, pp. 13-4 & 18 (cf. 123) and the others from Sidel, pp. 2-3 (cf. 11-2). These passages rework and explain the Conference's principles. The policies of North Vietnam are very similar (McMichael, pp. 329-32). On Cuba, see Fernandez, in Newell, pp. 15-6.

In spite of some unavoidable differences from country to country, the same principles were basically followed in Cuba and North Vietnam. Let us now see how these policies were translated into action.

Serving The People

People are most precious. The Chinese State therefore "views health care both as a human value, that is, as something intrinsic to the well-being of the people, and therefore to be promoted, and also as an economic value, a means to increase the productivity of the people." In consequence, it "has declared adequate health care for all the people to be one of its prime goals. For this reason, health problems are the concern not only of the medical professionals, but also of the economic and political strategists." *To fulfil its commitment to a more equitable distribution of the nation's resources, the State discourages private practice, strengthens the public services, and strives to narrow the gap between the urban and rural areas.* This is particularly the case since Mao's famous directive in 1965: "In medical and health work, put the stress on the rural areas!"[12]

Like other developing countries, China had three key problems concerning medical personnel: drastic shortage (which shall be considered below), heavy concentration in cities, and elitist attitudes. *To overcome the skewed distribution, tens of thousands of urban personnel were permanently or temporarily transferred to the countryside to serve on mobile medical teams.* The goal is, in fact, "to have one third of all urban medical personnel in the rural areas at any given time." In spite of its difficulties, this policy undeniably meant more manpower in the rural areas and made urban doctors and researchers to confront rural health problems. Medical personnel from the People's Liberation Army moreover played a major role in rural health delivery.[13]

"The elitist attitude of members of the medical profession, which tends to make them both insensitive and unresponsive to the health needs of the majority of the people", *had also to be struggled against.* This "implied obtaining the commitment of the medical profession, particularly the western-style doctor,

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12. For this paragraph, see Paterson, pp. 17-8 & 23-4, and Sidel, pp. 6 & 11.
13. On this, see Paterson, pp. 102, 26-7 & 109-12.

to the revision of the distribution pattern. In the words of Chairman Mao, it was to get the medical profession to 'serve the people.' In order to achieve this objective it was necessary for many of these doctors to realise that the chance to apply their advanced training and research capacities would have to be sacrificed for the moment in order to gain more equal distribution of medical services." The traditional system of incentives was challenged in many ways. The wage disparity between different grades of medical personnel was diminished by freezing the higher salaries till the lower ones began to catch up. The difference in status between specialists and PHCA doctors was minimised by their common work with paramedics. Much prestige is awarded for service and doctors are very often reminded of Bethume's utter devotion to others. *The Chinese thus "urge the medical profession to put service to the patient and the community above personal achievement and glorification."*[14]

"In Cuba, health is considered as one of the fundamental human rights and health services are free for everyone." Yes, *all services, "whether preventive or curative, environmental or personal, medical or social, as well as the drugs, are free of charge."*[15] More than 95% of the doctors are employed, and well paid, by the State. After the 1958 revolution, *the following developments* took place in health care: hospital services were expanded and made more efficient; *"a process of regional equalization occurred, with high priority given to the rural and indigent areas"*—An example can be given: in 1958, 65% of the physicians and 55% of the hospital beds were located in Havana which had only 22% of the population; by the early 1970s, both percentages had been reduced to less than 40% and the most remote areas had at least one doctor per 3,000 inhabitants.—; the services were refocused "away from the hospitals and towards the communities"; and there was *a phenomenal increase in the utilisation of health services by the total population.* "The yearly number of visits to the physician per inhabitant has increased from 1.9 in 1963 to 3.9 in 1973... In 1973 there

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14. ibid., pp. 102 & 112-4.
15. Fernandez, in Newell, p. 15, and Navarro, p. 15. Fernandez lists "professional visits, complementary examinations, hospitalization, drugs for hospitalized patients, and special programmes and campaigns" among these free services.

were, on average, 8.5 antenatal visits per pregnant woman, and child supervision visits, which began only in 1967, are now at the level of 4.5 per infant per year... Especially outstanding are the achievements in the institutional assistance of deliveries—slightly more than 96% of all births in the country in 1973."[16] The health indicators given in Table 14 reveal some of the effects of these changes!

The first Minister of Health of North Vietnam, Dr. Thach, thus assessed the evolution of the health services in his country: "I think the most important achievements are *the creation of the whole medical-health network down to village level,* putting medicine at the service of peasants living in the remotest hamlets, and *the training of medical and healh workers of peasant stock.*"[17]

Prevention First

These three countries emphasise "preventive rather than therapeutic medicine. This is being accomplished by formulating nationwide policies for sanitation, immunization, and other preventive measures and then mobilizing for their local implementation."[18] In China for example, the great "Patriotic Health Campaigns" successfully used war psychology to fight against the "four pests"—rats, flies, mosquitoes and sparrows (later replaced by bedbugs)—and various diseases, and to achieve other health goals. These campaigns aimed at (i) the systematic eradication of and continued vigilance against diseases, and (ii) the conduct of widespread health education programmes. According to a former Health Minister, *health education is indeed "the most important phase of public health work".* These campaigns "repeatedly stressed that health is important not only for the individual's well-being but also for that of the family, the community, and the country as a whole." Rather than being opposed to each other, *preventive and curative medicines are considered complementary,* for "a cured patient is one less source of infection." *The concept of preven-*

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16. For this paragraph, see Fernandez, pp. 16 & 26, and Navarro, pp. 23-8.
17. Quoted by McMichael, p. 34.
18. Sidel, p. II. Though written about China, this statement is equally valid for Cuba and North Vietnam.

tion is understood in a broad sense and includes social and political action.[19]

To help us visualize these efforts, *a few concrete examples* may be added. This is what goes on in the Chinese commune of Chiliying: "In some villages, one occasionally hears the ringing of a bell followed by calls to the people to get their doses of preventive medicine. Men and women commune members come out with bowls to dip and drink from buckets of steaming-hot Chinese medical brew. Many take bowlfuls home for their children. The herbal ingredients are distributed by the brigade health station to each production team which appoints a special person to brew them. There are preventive draughts against heat stroke in summer, enteritis and dysentery in autumn, and influenza in winter. In spring, medicine to guard against measles is given to children. This is only one of the *'prevention first'* measures in Chiliying. In its annual immunization programme, the country health department supplies large quantities of vaccines or preventive medicines against such diseases as smallpox, epidemic meningitis, encephalitis B, undulant fever, tetanus, measles and typhoid, malaria and polio. These are distributed free of charge by the commune clinic to the brigade health stations."[20]

In the Kouwang brigade, "barefoot doctors, with five public health workers from the production team, take advantage of various meetings for mass propaganda of elementary hygiene and disease prevention. Citing typical people or cases, they use both positive and negative examples to stress the importance of sanitation. Preventive medicine is also popularized through ballads mimeographed on red paper and posted on doorways to be read and remembered. All youngsters in middle and primary schools are organized for active propaganda work of this type."[21]

The first FYP (1961-65) of North Vietnam "concentrated on what they called *'the three major installations for rural hygiene'*, namely the double septic tank, the well with a curb, and the bathroom, in addition to the removal of stables away from dwelling

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19. For this paragraph, see Paterson (pp. 53-66), Sidel (pp. 3-5), McMichael (p. 25) and Bannerjee (pp. 7-8).

20. Chu Li & Tien Chieh-yun, "Inside A People's Commune", Foreign Languages Press, Peking, 1974, pp. 201-2.

21. ibid., pp. 202-3.

houses'. Of all the public health measures..., *the double septic tank* has perhaps been the single most important factor in the prevention of disease and the promotion of health. The idea is simple. It is easy for every family to carry it out, and it solves the day-to-day problems of sanitation—the 'faecal peril' of unorganized excretion—in countries where such things as drainage and main water supply are beyond the present bounds of possibility. It strikes at the root cause of many of the most intractable diseases of the developing countries—the gastro-intestinal infections, cholera, dysentery and the typhoids—and checks the menace of fly-borne infections." About ten years later, there were "one double septic tank, one well and one bathroom respectively for 1.4, 3.3 and 4.7 households." *To achieve such results, Vietnam has "swum against the stream in many respects.* To make physicians trained in the old faculties leave their consulting rooms or hospitals and become interested in digging wells and installing septic tanks, in a word, in the prevention of diseases, is contrary to their deep-rooted habits. Even a medical nurse of the old school would prefer giving an injection to going to see whether a septic tank is adequately built or not."[22]

Traditional & Western Medicine

China and North Vietnam moreover made serious efforts to integrate traditional and modern medicine—most likely for historical reasons, Cuba did not seem to follow this policy. *While considering modern medicine "better than old medicine", Mao advocated the combination* of both and declared: "Unite all medical workers, young and old, of the traditional school and western school, and organize a solid united front to strive for the development of the people's health work." The Ministry of Health therefore "sought a true synthesis between the two medical systems by formulating a scientific basis for traditional medicine and combining it with western practices." This meant "the training of western doctors in traditional practices and vice versa"; the reorientation and incorporation of traditional practitioners into the national health system; the use of moxibustion, herbal and other natural medicines, and also of acupuncture for disease treatment and surgery; and much scientific research. *The practices of tradi-*

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22. McMichael, pp. 40, 45 & 34 (cf. 40-50).

tional physicians "have been modified by the application of modern hygiene and scientific knowledge, and their treatment and medicines are used by western doctors as a resource to supplement modern medicine."[23] North Vietnam follows a very similar approach, makes a fairly extensive use of acupuncture, and possesses a particularly rich pharmacy.[24]

Community Health Workers

These three socialist countries were very creative in tackling their health manpower problems with available local resources. Confronted with the flight of about 3,000 of its 6,300 doctors soon after the revolution, *Cuba replaced them in less than a decade* by offering highly attractive incentives to doctors and medical students—50% of the latter were women in 1970!—, and *radically redistributed its medical personnel.* Though remaining largely subservient to doctors, nurses became the local pivot of health care, the "star of every day". Changes in medical education were introduced only in 1963, 1965 and 1968, but the overall evolution of the country had given a certain social consciousness to the physicians much earlier. In the 1970s, various schemes promoted the training of LHWs.[25]

The secondary medical schools of North Vietnam had trained by 1967 "8,000 assistant health workers for the commune network (assistant doctors and assistant pharmacists), and 20,000 auxiliary personnel (nurses, midwives and student nurses)". *These health workers are generally the sons and daughters of local peasants and spend 5 to 15% of their working hours in agricultural*

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23. Paterson, pp. 87-96. This chapter has a section on "the limitations and benefits of traditional medicine".

24. For details, see McMichael, pp. 56-7 & 188-207. In 1955, Ho Chi Minh told the National Conference of Medical Workers: "Medicine must have a scientific, national and popular character... To widen the scope of medical activities, you must apply yourself to studying and integrating traditional and modern medicine" (p. 192). Each family is encouraged to grow some medical plants for its own use and for sale, and North Vietnam now exports some pharmaceutical products extracted from the country's flora.

25. On this, see Navarro (pp. 26-39), Conover... (pp. 4-6), and Fernandez (pp. 21 & 25).

production to keep a most intimate contact with their social environment. For "public health and medical work in the villages, which involves in essence mass activity, requires besides a certain professional competence, a well-developed political consciousness and a thorough knowledge of the area, the people and their ways and customs. Accordingly, the personnel selected, who are so to speak 'born and bred' in the areas they represent, and are bound to their fellow villagers by many close ties, have much greater chances of success in their work than those who are 'outsiders'."[26]

China resorted to still bolder strategies to solve its manpower problems. From the mid-1950s, *concerted efforts were made to retrain the* 500,000 *traditional practitioners, assign them to hospitals and clinics of various types, and integrate them into the system.* On account of their close relationships with people, especially villagers, these practitioners often act as channels of change and play an important role in the delivery system. *The course in western medicine was shortened to about 3 years in 1958 and in the 1970s. Medical schools were closed in 1966 and, at their reopening in 1970, their aims and curricula were radically altered.* It is estimated that doctors having followed the long and short course respectively numbered 180,000 and 172,000 in the early 1970s. As already mentioned, most of them were posted, at least temporarily, in rural areas...[27]

Besides full-time assistants and paramedics, about one mn part-time auxiliaries—such as barefoot, worker, and Red Guard doctors—were also trained, mainly after 1966. Most of these *barefoot doctors* "are young people of poor and lower-middle peasant background, with a fairly high degree of socialist consciousness and at least a junior middle-school education. They are accepted for training on the basis of nomination by the masses and confirmation by the Party branch." Their initial training lasts three to four months and health professionals are involved in training, supervision, and referral.

Barefoot doctors "provide environmental sanitation, health education, preventive medicine, first aid, and primary medical care while continuing their farm work." "Their main task is pre-

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26. McMichael, pp. 74-6.

27. For details, see Paterson, pp. 90-6 & 101-9.

vention; they are the leaders in teaching hygiene, cleanliness in food preparation, the folly of smoking and the benefits of exercise. They immunise the children against infectious diseases and advise on the contraceptive programme... Although they diagnose and treat only minor illnesses and usually rely on traditional medicines, an examination of their 'black bag' of drugs and equipment discovers not only a variety of herbal medicines, acupuncture needles, bamboo cupping vessels and moxibustion sticks, but penicillin, barbiturates and other western drugs lying with hypodermic syringes, stethoscope and first-aid requisites." On the whole, foreign visitors were impressed by their skills. *Similar health workers are active in the factories and the urban neighbourhoods.*[28]

Mass Mobilisation & Organisation

China, North Vietnam and Cuba energetically promoted self-reliance and mutual help in meeting health problems. They took seriously Lenin's guideline—"The protection of the health of the working people must be the concern of the working people themselves"—and *succeeded to motivate, mobilise and organise their people, even at the local level. Their approach was based on a tremendous confidence in the people.* As Jen Min Jih Pao proclaimed, "the masses have boundless creative power. They can organise themselves and concentrate on places and branches of work were they can give full play to their energy; they can concentrate on production in breadth and depth and create more and more welfare undertakings for themselves."[29]

In Cuba, health planning "is centralised at the ministry level with a heavy professional input, but implementation is decentralized at the local level, with widespread public participation." When a conflict arises in the health sector, decisions increasingly favour public preferences. "*Mass organisations implement public health policy.* Mass organisations really do involve

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28. The quotations are taken from Chu Li (op. cit., pp. 205-6), Sidel (p. 6, cf. pp. 6-9 & 11), and P.N. Benjamin (in "Deccan Herald", June 10, 1982, p. 6). For details, see Paterson, pp. 105-9 & 118-22.

29. These quotations are respectively given in McMichael (p. 332) and Paterson (p. 53). For details on Vietnam, see McMichael, pp. 27-8 & 225-6.

a large majority of the population. Almost everyone in the nation is a member of a Committee for the Defence of the Revolution (CDR), and almost every woman is in the Federation of Cuban women. These two organisations are the main distributors of health information and are the agents who ensure that children receive inoculations, that pregnant women receive prenatal care, and that diabetic patients report to the clinic when they are supposed to. Nurses work closely with these organisations, instructing the local leaders so that they may instruct others."

"*The CDRs are organised block by block in the cities and into analogous units in the rural areas, and each unit has a health activist.* This technique of having the entire society organised block by block proved tremendously successful in eliminating infectious disease. Mass immunisations could be finished in a few days, peasants could assimilate basic facts in the control of parasitic infections, and mothers were taught when it was imperative to rush a child to the hospital and when the child's illness was likely to be self-limiting. *Thus, the Cuban health care systems is integrated into other community activities and much, if not most, 'health care' is delivered in the community in the form of health education."*[30]

China is famous for its health campaigns. "*The major factor in the Chinese success in reducing the threat of communicable diseases has been the technique of mass mobilization, which has engaged whole communities in pursuing the goal of disease eradication.*" "To understand the mechanics of mass mobilization, it is necessary to examine briefly what the Chinese have called the 'mass line'. Based on the Maoist belief that the common people, given the proper leadership and necessary power, knowledge and motivation, can successfully cope with highly complex problems, *the 'mass line' is a basic tenet of China's socialist policy.* A line of action, it is held, can serve the people only when they are thoroughly committed to that line; therefore *there is an attempt in all political, economic and social activities to maintain interaction between the leadership and the people.*"

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30. These quotations are from Navarro (p. 52, cf. pp. 41-56) and Conover... (pp. 1 & 4). According to Navarro, 3 mn citizens out of a total population of 8 mn were members of the CDRs in the late 1960s

"After the leadership has proposed a broad policy as a programme of action, it is discussed from the highest ranks to the lowest in sometimes lengthy and repeated study sessions; *it is modified* as conditions require and *is carried out only after the public is tacitly or actively in agreement with its fundamentals, that is, after it has become the 'mass line'.* In this way, an attempt is made to involve everyone and to commit all the people to the national goals. Developing the 'mass line' in health work follows the normal procedure. After making information available to all community members through films, lectures, posters and drama, the local authorities call meetings to discuss the disease problem. These meetings aim both to inform the people on health questions and to mobilize and enlist them for action to control and prevent disease. Decisions follow understanding." This technique, which uses all available local resources, brought about phenomenal successes in health care.[31]

Health & Revolution

The health achievements of China, Cuba and North Vietnam are clearly related to their radical socio-economic, political and ideological transformations. Health goals were pursued along, and as part of, other egalitarian targets and greatly benefited from overall socio-economic and political developments. *From these countries' experiences, one can see what improvements in nutrition, water supply, sanitation, education, mobilisation, employment, land distribution, etc., concretely mean for health standards!*[32] The previous pages have repeatedly stressed this point...

One can however go further and link progress in the health field with a socialist revolution. "The Chinese health care system is an integral part of the new Chinese social structure, the establishment of which was made possible by the success of the Communist revolution that culminated in 1949. The revolution destroyed the power of a small, economically and politically powerful elite class which controlled the national re-

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31. Paterson, pp. 55 & 57, cf. 53-71. MacLeod remarks: "The system of health care is unusually flexible and adaptable to a variety of situations because of the Chinese blend of *decentralization, local autonomy,* and active *popular participation* at the grass roots level." (p. 9; author's emphasis).

32. Navarro's analysis particularly emphasises these factors (pp. 1-14).

sources, and it established instead a more mass-based political, economic and social structure. This power structure, concentrated in the Communist Party, emphasized among other things a more equal distribution of resources and committed people to work toward socialism. *The health care system then is one result of a change in the political and economic basis of the Chinese society.* It is also the consequence of a radical upheaval in society which destroyed old structures, set up new social values and freed the people for new ways of thinking. *The Chinese would say that revolution is a necessary prerequisite for radical change in health care delivery."*[33]

Navarro also asserts: "The Cuban experience puts a question mark on the well accepted argument used by some health planners that a lack of resources prevents the provision of health services to entire populations in most developing countries. Contradicting this argument, Cuba... is, in fact, providing comprehensive health services (not without great sacrifices) to the whole population without direct payment involved, *as a result of its philosophy of equalization and comprehensiveness in health care."* The Cuban experience indicates that *"the lack of health services coverage in most developing countries may be due not so much to the scarcity of resources... but to the ill distribution of these resources within and without the health sector."* And it would seem unlikely that such a redistribution of resources (within and outside the health sector) would have occurred without substantial redistribution of the decision-making power of the controlling groups and classes.[34]

"China has been able to bring its large manpower resources to bear on health problems through the technique of mass mobilization. This process has been possible because of the political interaction between the leadership and the common people. In few other countries has the leadership made such heavy and sustained demands on the population as in China. That is to say that the *Chinese political system has been an important factor in the construction of its health care system."*[35] *This is why many writers emphasise the importance, and even the necessity, of a*

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33. Paterson, p. 124.

34. p. 58.

35. Paterson, p. 124.

national political decision for change and of an overall process of democratisation—a broad movement of people's mobilisation and organisation. Navarro for example writes that the impressive progress of Cuba... would not have been feasible within the rather limited time period were it not for the massive participation of the Cuban population... —the mobilization of the public by the mass organizations."[36] With a slightly different emphasis, MacLeod sees the prerequisite of the Chinese success "in the realm of social organization, mass motivation and morale": "The really distinctive element may well be China's present *socio-political philosophy* including special *ethical principles.*"[37]

Conclusion

The health successes of China, Cuba and North Vietnam did not appear in a smooth overnight process. They were rather the product of bold strategies and trials, with ups and downs, failures and readjustments, and even tensions and struggles. And today, there still remain many problems and weaknesses. Only brevity forces us to leave all these elements in the background... *All the same, very much was achieved, and very quickly; in fact, much more than was thought possible, and much more quickly.*

But, what elements of these experiences can be applied to other settings? What is profitably transferable? What "might be of value to (nations and) communities in other cultures and social systems?" Experts warn that *the experiences of these countries and their health care systems cannot be, as such, transplanted to other countries.* For they are too intimately connected with specific revolutionary processes and overall socio-economic, political and ideologial changes. This fundamental limitation does not however make everything irrelevant. "If the systems as such cannot be borrowed wholesale *there are still many elements that are of value.*"[38]

Though the final chapter integrates the positive elements learnt from these socialist countries, a few key insights should be summarised here. *First, these experiences clearly reveal how*

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36. p. 57. On this, see also Newell (pp. 198-9) and Banerji (in Naik, pp. 31-2).

37. in Akhtar, pp. 10-1; author's emphasis.

38. For this paragraph, see Paterson (pp. 7 & 123-7), MacLeod (pp. 11-2), and Navarro (p. 57).

faulty are certain widespread assumptions regarding health care: "that more and better curative facilities will assure improved general health standards...; that only highly trained manpower can deliver good health care; that medical care can be independent of such activities as health education and other preventive measures; and that 'disease and hospital-oriented systems' are, without reservation, the most appropriate means to solve the problems of a community's health." *Second, these experiences focus our attention on three key questions:* "(1) Who are to get the health care services? Shall it be the few (the privileged) or the many? The young or the old? (2) What kind of services are to be provided? Shall the emphasis be on the cure of the ill or the protection of the healthy? On the common or the esoteric diseases? (3) How will the services be delivered? By what combination of expensive, highly qualified and para-medical personnel? By what kind of organisation and institutions—clinics or specialist hospitals?"[39]

Third, China, Cuba and North Vietnam highlight the above-mentioned key principles, which can very well serve as the basis of an alternative health care system oriented towards people's needs. They also offer a wealth of practical suggestions and examples for the implementation of these principles. Fourth, and perhaps most importantly, these experiences fill us with hope, for they have shown beyond any doubt that, given the proper political will, the health status of developing nations and underserved communities can be greatly improved with the knowledge already available and at a cost that these nations and communities can afford.

The State of Kerala[40]

The remarkable health progress of Kerala is agreed upon by experts. Panikar for example writes: "Judged in terms of

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39. These statements are taken from Paterson (pp. 12-3), but are not however presented as the experiences of socialist countries.

40. See for example Zurbrigg (ch. VII), P.G.K. Panikar ("Resources Not The Constraint on Health Improvement. A Case Study of Kerala", in EPW 1979, pp. 1803-9), and K.S.J. Rao ("Kerala: A Health Yardstick For India", in MFCB 58, pp. 1-4). For further references, see Panikar and Zurbrigg.

conventional indices of health such as general mortality rate, IMR and life expectancy, *Kerala stands out from the rest of India.* What really distinguishes the performance of Kerala compared to that of other states in India is the improvement in the health status of the rural population in general and of children and infants in particular."[41] And Ratcliffe adds: "Kerala has managed to achieve the demographic transition from high (premodern) to low (modern) birth and death rates—something no other Indian state has been able to attain. Indeed, the magnitude of Kerala's fertility decline—the birth rate fell from 39 in 1961 to 26.5 in 1974—*has never before been observed in a nation with comparable levels of income and undernutrition. Other indices of Kerala's social development are equally surprising:* levels of literacy, life expectancy, female education, and age of marriage are the highest in India, while mortality rates, including infant and child mortality, are the lowest among Indian states."[42] Table 15 gives clear evidence of these unique achievements.

TABLE 15[43]

State-wise Health Indicators

States	Death Rate (1980)		IMR (1978)	
	Rural	Urban	Rural	Urban
1. Andhra Pradesh	12.4	6.8	127	66
2. Jammu & Kashmir	10·5	5·6	81	51
3. Karnataka	10.7	6.6	90	58
4. Kerala	7.1	6.5	45	29
5. M.P.	16·4	9·3	151	87
6. Maharashtra	10.9	7.1	88	63
7. Punjab	9.2	6.6	126	76
8. Tamil Nadu	12·4	8.3	120	63
9. U.P.	17.6	10·3	184	114
10. Delhi	8·9	6.4	110	64
11. India	13.5	8.0	137	74

41. p. 1809.

42. Quoted by Zurbrigg. The author adds that *Kerala's decline in*

Kerala's health indices can also be interestingly compared to those of other nations.[44]

"Kerala's achievement in the health field becomes all the more significant and of great relevance to low income countries when viewed against the facts that the level of per capita income, per capita expenditure on health, and medical infrastructure measured in terms of bed-population ratio, doctor-population ratio, etc., are even lower here than in some other Indian states."[45] In the late 1960s and early 1970s, Kerala indeed ranked 10th among the 18 states in per capita domestic product, 6th in per capita expenditure on health, and 5th in doctor-population ratio—it was however 3rd in bed-population ratio (after Himachal Pradesh and Jammu/Kashmir) and 1st in the percentage of beds located in rural areas. In spite of some controversies, it can be said that energy and food intakes remain low in Kerala, and below the national average. *Kerala's health improvements do not therefore result from greater economic and health resources.*

To what, then, should these striking achievements be attributed? The answers to this question emphasise different factors. According to Panikar, "the reason for the better health status in Kerala lay... in the state having given *equal importance to preventive and promotive measures* like sanitation, hygiene, immunisation programmes, infant and ante-natal care, health education, etc., *as to curative medicine.* Moreover, *the spread of education,* especially among women in the rural parts of Kerala was probably a crucial factor contributing to the high degree of awareness of health problems and fuller utilisation of the available health facilities."[46]

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birth rate does not result from direct population control efforts. but from "a broad social response to structural reforms in its political economy." According to Panikar, "the message of Kerala's experience is that *improvement in general levels of education, health and degree of participation of the masses in the process of modernization are the pre-conditions for a perceptible and sustained fertility decline"* (quoted ibid.).

43. Taken from HS 1982, pp. 25-6 & 29.
44. See Tables 7 & 14, above pp. 49 & 86.
45. Panikar, p. 1809.
46. ibid. The author adds: "The rate of utilisation, which is governed by the accessibility of the institutions or their spatial distri-

In his presentation, Pran Chopra insists on the prominent role played by a *better distribution of resources.* "Kerala does not spend more per capita upon public health than other states and does not have more doctors, dispensaries, or hospital beds per hundred of the population. But what it spends and what it has are more evenly distributed while in most other states they are disproportionately concentrated for the benefit of the urban and less poor section. Hence, there is much higher utilisation of public health facilities in Kerala and much closer proximation of rural to urban and female to male health standards than in any other state, and distinctions between the richer and poorer peoples' health are minimal." There is also a more equal distribution of the available nourishment within the state and even within the family.[47] Ratcliffe therefore concludes: "In terms of social and economic development strategies, Kerala's successes have been achieved not by allocation of *more* resources, but rather through a more equitable distribution of *existing* resources, goods and services."[48]

Zurbrigg goes further and argues that "equitable distribution" in itself does not explain Kerala's evolution. *"Redistributive policies, and governments committed to such policies, did not appear by chance... Rather, such policies and responsive governments intimately reflected, and were a product of, an increasingly politicized base of consciousness and action from much of the labouring poor...* In other words, the force for the remarkable achievements in health status and education so apparent in Kerala, and which distinguishes it so clearly from other states, came not primarily from above, but *from below." It is, to a great extent, the growing consciousness and organisation of the poor*

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bution and the general health consciousness of the population, is greater in Kerala." The *"high level of literacy and education among females in Kerala is the one factor which, in our judgement, has contributed most to the improvement of the health status of infants and children"* (pp. 1807 & 1809). Rao thinks along the same lines. On this, see also C. Gopalan, in "Alternative Approaches...", pp. 229-30.

47. "Kerala Phenomenon...", in IE 1980, Nov. 7th, p. 8, and Rao, pp. 3-4.

48. Quoted by Zurbrigg; author's emphasis.

that brought about these more egalitarian policies.[49]

The conclusions of Rao and Panikar are also worth quoting. The former states: "The experience of Kerala shows that *even with limited financial resources, proper health measures and improved rural and female literacy are possible and that these may aid improving child health and child nutrition.* Kerala can therefore be considered a yardstick for judging health status in the country." And the latter: "The conclusion to which this case study leads is that given *proper policies and priorities, lack of resources need not be an impediment to the improvement of health status even in low income countries."*[50]

There is no need to end with a summary of what we learnt from developed capitalist countries, socialist countries, and the State of Kerala. It might however be useful to point out that most of the findings converge. The world is increasingly becoming a global village and the experiences and reflections of various countries influence each other. The experiments and discoveries of socialist countries had for example much to do with the growth of CHCA and PHCA. And the recent western criticisms of the "medicalisation of life" are relevant for the future of mankind everywhere. The *"emerging trends and meaningful experiences" we have studied in this chapter stimulate us with their inspiring insights and their messages of hope. Still more importantly perhaps, they challenge us to investigate what can be concretely done in our own country. This is the last chapter's scope.*

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49. Ch. VII. The text is yet to be finalised. This whole chapter is well-documented and thought-provoking.

50. pp. 4 & 1809, respectively. The "Health For All" document agrees (pp. 18-9).

6. Possibilities of Relevant Action

The previous chapters have, on one hand, highlighted the pathetic health situation of the majority of our people, the specific disease pattern of our developing country, and the clear inadequacy of our health care system. They have also, on the other hand, shown the basic class character of the Indian state, which fundamentally accepts and supports our inegalitarian society and its biased health system. Other countries—such as China, Cuba and North Vietnam—and the State of Kerala have proved that, even with limited resources, major achievements are possible, but our Government lacks the political will to promote radical socio-economic and health alternatives. Yet, some significant progresses have taken place in the understanding of health issues and systems, and the Indian state is increasingly pressurised to recognise its failures and to introduce various reforms in favour of the masses. Despite a growing crisis of confidence, no revolution can be foreseen in the near future... *In this overall context, then, what contribution can health professionals and social activists concretely make? How can they answer the major health needs of the poor and oppressed and foster health justice? Is CHCA relevant? Is it the solution or, at least, a part of the solution? How to tackle the root causes of the problems? Can health issues be made use of to conscientise and organise the masses, and thus promote the broad socio-economic and political changes required for major health breakthroughs?*

Bang and Patel thus describes the ongoing debate: *"The prevalent thinking in the Geld of people's health care shows a wide range with two schools of thought at two poles. One school feels confidently that the panacea for the health problems of the people has been found. It is the alternative approach of health care delivery* usually meaning utilisation of non-professionals (VHWs) and appropriate technology in health care. *Another school is equally confident that the only real cause of all heath problems of the people is the present economic system, and nothing can be and should be done to solve these health problems unless*

the present economic-political system changes by revolution. The first leads to ill-founded euphoria, ... (the second) to inactive cynicism towards the burning health problems of the people."[1] And there is evidently a great variety of positions and attitudes between these two extremes.

A second set of questions inevitably arises. If fundamental changes in the national health system can be brought about only by radical changes in the socio-economic and political structures of Indian society—and this seems evident—, *what is the relevance of micro-level involvement?* Is it worthwhile to dedicate oneself to raising the health standards of neglected areas and social groups? Are CHCA projects—and at what conditions?—useful? Is it worthwhile to work locally for conscientisation and organisation? *And how is this micro-level involvement related to the macro-level of national health policies and broad political action for health justice and societal change?*

Without claiming to settle this complex issue, it can be pointed out here that both micro- and macro-level actions are indispensable. "While we must not lose sight of the ultimate goal of structural change and 'total revolution', we also must be able to promote structural change at the micro-level that offers the poor and oppressed an opportunity to be conscious actors in the process."[2] Without local consciousness and commitment, large political movements often remain authoritarian and unresponsive to

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1. In Bang and Patel, pp. xi-xii. This book contains an interesting summary of the 1978-79 MFC debate on these issues (K.J. Rao, pp. 219-30, cf. also A. Phadke, pp. 243-6). According to Zurbrigg, there are "two very different approaches to the problem of societal ill-health. That is, a social and political analysis, leading to political action, on the one hand; and on the other, the current and fashionable enthusiasm for PHCA delivery... Each is based on an entirely different interpretation of the nature and source of ill-health. Whereas the provision-of-basic-health-needs approach posits lack or absence of specific ingredients (technical, organizational, informational or attitudinal) as the source of the problem, the socio-political interpretation looks at the presence of particular factors—oppressive economic structures, dependency, and as symptoms of these forces, hunger and powerlessness—as the source of ill-health" ("Conclusion"; the text is yet to be finalised).

2. Volken, in "Moving Closer...", p. 27, cf. pp. 27-9.

people's needs. And they cannot achieve much if ever they capture power. On the other hand, micro-level action is evidently powerless to bring about any large-scale structural change. *In consequence, micro-level involvement should lead to macro-level involvement, which should in turn intensify micro-level participation. These two types of action are in fact complementary.*

There is indeed, nowadays, an important debate on the possibilities of relevant action in the health field. To guide our discussion throughout this chapter, we have outlined the different types of health work in Table 16. Each type or approach represents a focus of action. Though most people and even health professionals still take for granted the existing western model (approaches 1 & 2), the experts clearly recognise that this

TABLE 16[3]

Types (Approaches) of Health Work

1. Curative network: private & public services
2. Health programmes/projects: extension of basic services (through PHCs, dispensaries, clinics, etc.), including preventive and educational programmes, but without community participation & socio-economic dimension
3. CHCA (with socio-economic dimension & community participation)*
4. CD with health dimension & community participation
5. a) CHCA with conscientising dimension
   b) CD with conscientising dimension
6. Conscientisation & political action with socio-economic and health programmes
7. Conscientisation & political action, inclusive of health issues, but without health programmes.

3. Rather than being absolute categories, these divisions only indicate different emphases. The reality is much more complex. *According to us, genuine CHCA should include at least a concern for conscientisation/political action (Table 19). We use a different classification here, for many CHCA projects do not in practice comprise this dimension.

system is irrelevant, inefficient and unjust. There is hardly any disagreement on this point. *The real debate concerns the relative importance of CHCA, CD and conscientisation/political action (approaches 3 to 7).* The two sections of this chapter, respectively entitled "Community Health Care" and "Conscientisation, Political Action and Health", explore the manifold dimensions of this debate and pinpoint the different "possibilities of relevant action". We hope that our findings will be both enlightening and inspiring!

Community Health Care

Many articles and books have, in the last decade, described various CHCA projects,[4] enounced the major principles and characteristics of CHCA, and discussed the contributions and limitations of this approach. In fact, many expressions—such as "primary health care", "comprehensive health care", "community health care", etc.—are used to describe what is needed in India today. We prefer the phrase "community health care", for it highlights the role of people's participation.[5] Such words how-

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4. See for example "Alternative Approaches...", and the books of Fernandes, Newell, Rifkin and Volken, all listed in the bibliography; and L. Barreto (op. cit.), V. Djukanovic & E.P. Mach (eds) ("Alternative Approaches to Meeting Basic Health Needs in Developing Countries", Unicef/Who, Geneva, 1975); D. Korten, "Community Organization and Rural Development: A Learning Process Approach", "Public Administration Review", Sept. Oct. 1980, pp. 480-510), and V. Benjamin & M. Mukhopadhyay ("Comprehensive Health & Development Project—Pachod", cyclostyled report, 1981).

5. CHCA indeed means "having the community decide how to meet and take responsibility for their own health needs", and it "must be built from the grassroots up not given from the hospital down to the people." CHCA enables people to choose their own services, personnel and medicines, and thus fulfil their aspirations. *"Community health"* goes beyond *"community medicine"*, which only extends the coverage of the medical services by hospital-based doctor-administered programmes—through dispensaries, clinics and other outreach efforts. "Community medicine" may consult people, but "community health" involves them. Hence, *Newell equates "community medicine with basic health care services and community health with PHCA."* The expression *"primary health care"* draws attention to the fact that basic services should be given priority over sophisticated ones—espe-

ever hide a fairly wide variety of concepts and approaches. Let us therefore clarify this important matter by considering two interrelated themes: *the exact potential and the basic characteristics of CHCA*. This will enable us to discover whether CHCA constitutes a relevant form of action.

Potential and Limitation

The real contribution of CHCA projects is much debated. Some praise their accomplishments and potential, while others stress their inbuilt limitations. *Besides their conscientising function, which shall be analysed later, CHCA projects are claimed to make three major contributions. First, they can—to varying degrees—improve the health standards of a given area or community.* Though the data collection of most projects is inexistent or defective and incomplete, some of them have well documented that the health indicators and/or other significant targets have shown definite improvements because of their work.[6] Tables 17 and 18 give the well-known examples of Jamkhed and Miraj.

The potential of CHCA projects to raise health standards is generally recognised, but remains, to a good extent, limited by broad socio-economic, political and ideological determinants. It also greatly varies according to several subjective and objective factors: the efficiency and commitment of the health workers, and their relationships with the people; the importance given to health education, nutrition, sanitation, water supply, housing, immunisation, etc.; and the impact of socio-economic programmes. *Curative extension work, preventive health measures, and socio-*

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cially in the context of limited resources. The "good for the many" should be preferred to the "best for the few". This is a social justice requirement. *"Comprehensive* (or *"integrated") health care"* stresses another dimension, namely, the search for "total health" and "total development"... For this paragraph, see Rifkin (p. 11, cf. 9-14) and "Alternative Approaches..." (p. 195).

6. For an assessment of several Indian experiments, see A. Timmappaya & K.G. Rao, in "Alternative Approaches...", pp. 179-90. *The successes of Jamkhed* (in Newell, pp. 84-6; Fernandes, p. 42; and "Alternative Approaches...", pp. 100-1), *Miraj* (in "Contact" 44), *and Pachod* (Benjamin, op. cit., pp. 1-15) *are particularly clear.*

TABLE 17[7]

Some of Jamkhed Achievements

	Project Area		Non-project Area
	1971 Jan.	1976 Jan.	1976 Jan.
Population surveyed	1490	1491	1405
Eligible couples	269	252	244
Family Planning (%)	2.5	50.5	10
Birth rate	40	23	37
Immunized underfive children (%)	1	84	15
Infant mortality	97	39	90
Antenatal care (%)	0.5	78	2

TABLE 18[8]

Some of Miraj Achievements

	1974 Jan.	1976 Jan.	1977 Jan.
Birth rate	26.3	24.5	21.4
Death rate	9.8	9.	8.5
IMR	67.6	34.4	23.1
Neonatal mortality rate	42.1	28.	21.2
Post neonatal mortality rate	25.6	6.5	5.3
Completed doses of DPT	2%	60%	85%

7. Adapted from "Alternative Approaches...", p. 100.

8. Adapted from "Contact" 44, p. 13. The whole issue describes this "Integrated Health Services Project", the biggest rural health project in India with a coverage of about 230,000 persons. On this, see also "Alternative Approaches...", pp. 114-23 & 185-6.

economic projects seem to possess their respective ceilings with regard to health improvements.[9]

Second, CHCA projects can promote the human development of the community—its consciousness, leadership skills, organisational capacities, self-reliance, etc. "One has to look beyond the figures, the targeted achievements, at what happened to the values, attitudes, expectations and practices of the people concerned"—both the health workers and the beneficiaries. The former can indeed grow "as persons, leaders and opinion-makers in their community", and the latter in self-confidence and responsibility. This process of human development is a must for permanent changes.[10] "Only by participating in building their own future can people grow, hence people's participation must become a reality. In deciding the nature of health care, attention should be given not only to people's health needs, but also to the people's ability and creative talent in the processes of planning and implementation." If this is done, the effects will go beyond the health field. This overall growth is very important, for "people's development is the criterion of genuine progress."[11]

These qualitative achievements—especially those that concern not only the LHWs but the whole community—are evidently much more difficult to measure than quantifiable objectives

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9. Our whole analysis has emphasised the prominent role of broad societal factors and the limitations of purely medical interventions. A. Phadke even writes that, compared to other factors. curative services are *"marginal"*. "It is beyond the capacity of a medical team to provide food, water, sanitation, housing, education, proper educational and cultural environment. Medical work alone thus will only *marginally* improve the health status of the population in an area..." (as reported in MFCB 82, p. 7). *As a result, some doctors question whether it is worth being involved in purely health projects* (ibid.; MFCB 26, p. 2; and Bang/Patel, pp. 222 & 228-9). In fact, the CHCA projects, which show appreciable results, comprise important socio-economic programmes. *The extent to which health improvements should be respectively credited to socio-economic progress and medical work is however often difficult to ascertain.*

10. Mukhopadhyay, in Benjamin, op. cit., part II, pp. 1-2, cf. 1-21. The whole evaluation insists on this dimension.

11. Kaithathara, in "Social Action" 1981, p. 353, and in Volken, "Learning...", p. 88, and Fernandes, p. xxxviii.

and CHCA evaluations most often remain vague in this area. *The potential of CHCA projects for human development moreover largely depends upon the authenticity of the people's participation.* Though considerably impaired by the non-participatory nature of our socio-economic and political systems, *people's participation will usually be greater in socio-economic and conscientisation/political programmes than in purely health projects.* In any case, the contribution of CHCA projects to the creation of a participatory culture and thus to human development is welcome, and "all efforts to involve the people, especially the needy and the oppressed, in making decisions and their implementation should be made."[12]

The third contribution of CHCA projects lies in their motivating and enlightening value. This is why they are often called "model" and "pilot" projects. By coming into contact with successful efforts, other health professionals are sometimes inspired to imitate them. By their experiments, CHCA projects moreover test various ideas and highlight certain possibilities of action. They thus play a pioneering role and help to establish a critique of the existing system and to evolve new approaches, strategies and systems. *They show what could be done on a large-scale with proper political will and build up pressures for meaningful changes. They can serve as blueprint for radical action when a revolutionary Government finally takes over.*

In an interesting passage, H. Sethi develops some of these insights: "Arole's work in the area of health care in Jamkhed is useful and meaningful not only because the covered population gets better health care (which they do); but because *we learn how alternative health care delivery systems can be designed and run.* We put into operation systems which challenge the conventional notions of health care, explore the possibility of alternative doctor-patient relationships, demonstrate the value of preventive and social medicine over expensive hospital-based curative techniques, and above all converts one ostensibly neutral technical profession and task into a 'political' one. An Arole or a Zafarullah Chowdhary not only becomes a symbol for others

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12. Abhay Bang, "People's Participation...", in MFCB 64, p. 2. The author speaks of a *"marginal"* contribution. He has expressed similar ideas in a letter to "Link", Feb. March 1982, pp. 7-8. On this, see also I. Qadeer, in MFCB 23, pp. 1-3.

in the profession, the work at Jamkhed kendra challenges the very basis on which the medical mystification is based. The values and operating style of the profession get a jolt... *The work ... is a constant reminder of what in fact is possible, even within the existing structures, and this to my understanding, is an extremely important political task.*"[13]

Though some writers hold that such projects can hardly be reduplicated—mainly because they are too costly and largely depend on the special qualities and zeal of the organisers, and on account of unjust societal structures—,[14] CHCA organisers often claim the contrary.[15] The facts themselves seem to be progressively clarifying this issue. *It is indeed difficult to deny that CHCA projects, while not reproduced in all their components, have an increasing impact on Government policies—for example through the "Health For All" document—and set a trend that is, at least to some extent, followed by more and more health workers.* In spite of the unavoidable constraints imposed by the exploitative structures of today's society, an important contribution has certainly been made in this field.

While these limited, but significant, contributions are generally acknowledged,[16] *three interrelated criticisms are made with*

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13. In "Madras Development Seminar Series", bulletin, Dec. 1982, pp. 176-85. For other thought-provoking texts, see K.J. Rao, in Bang & Patel, pp. 221-2 & 227.

14. See for example Bang/Patel (pp. 224 & 227-8), Newell (p. 200), I. Qadeer (in Patel, p. 57), and Banerji (in Naik, pp. 32-3, and in "Political Economy...", pp. 20-1). Arguing that the "Government spends a lot of money on wrong priorities and allocates meagre resources for health due to which the poor mainly suffer", Abhay Bang makes an interesting suggestion: "What voluntary agencies could be doing is to decide the minimum health care every person should get and try to show the ways of doing it at the low cost level, whatever the cost should be compared to the Government's per capita health expenditure. This is the way by which one can press the system to mend its ways. *Voluntary health projects should not try to fit into the system's false limitations.* While deciding the minimum health care, the nation's economic standard (GNP or per capita average income) should be taken into consideration but not the per capita health expenses of the Government." (in MFCB 64, pp. 7-8).

15. See for example "Alternative Approaches..." (pp. 185-6), Arole (in Newell, p. 89, and Fernandes, pp. 40-1), and C. Behrhorst (in Newell, p. 49).

regard to the side-effects of health programmes. CHCA projects are first of all said to strengthen the existing power groups, for the health resources usually fall into their hands. The rich and powerful thus acquire another tool for increasing their social control over the poor and oppressed. As already pointed out in the analysis, health services also often reinforce the dominant cultural values—once again, to the advantage of the power groups. CHCA projects are moreover accused of creating an additional dependency of the local community towards the donors and the health workers, and making the people less self-reliant. And they are finally blamed for giving the illusion that health problem can be tackled without touching the key socio-economic and political issues. In these various ways, CHCA projects cover up the real problems, defuse pressures for radical changes, and perpetuate and even strengthen the status quo.[17] Though it is very difficult to weigh these negative side-effects against the positive contributions, *it should be recognised that these criticisms represent serious dangers and that many projects fall prey to them. And that,* in this matter also, *success or failure basically depends upon the decision-making process, the degree of people's participation, and the existence or non-existence of a conscientising component in the CHCA projects.*

Let us conclude with two quotations. The 1983 Bangladesh Conference on "People and Health" declared that, *though socio-economic and political factors "are the major determinants of the health status of the people, the health services have an important role to play.* Constraints do exist in the present situation but health care workers will have to undertake the responsibility of trying to improve the health status of the people within the existing constraints instead of sitting silently and waiting for the ideal conditions." Abhay Bang put this insight more vividly: "Let me take the example of a patient who has diabetes with

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16. Very few, if any, writers totally reject CHCA projects. Yet, those who emphasise the importance of socio-economic and political factors tend to give a lower rating to the three achievements we have mentioned. In our opinion, the data so far collected do not enable one to be very precise and categorical.

17. For such criticisms, see for example Banerji (in Naik, pp. 33-4), Bang/Patel (pp. 223 & 227), R. Jeffery (in EPW 1982, pp. 1496-7), I. Qadeer (in MFCB 23, pp. 1-3), and Zurbrigg (chapters 6 & 8).

carbuncle. We know that the carbuncle is not the basic disease. It is diabetes which is the fundamental culprit. But we also know that the infection aggravates the diabetes. Hence while we try to control diabetes we also try to attack the infection. We don't neglect the infection. *Similarly in the present-day society, though the whole economic political system is the fundamental malady, health problems do need attention."*[18]

The rest of the chapter will tell us how health professionals and social activists can optimise their contributions to the health and total well-being of the people, and obviate the dangers already pointed out. This can be done by going beyond purely health programmes and becoming involved in genuine CHCA projects and conscientisation work. In this way only will the "possibilities of relevant action" in the health field be fully revealed.

Basic Characteristics

Table 19 summarises the basic characteristics of CHCA.[19] The emphases—and the successes or failures—may vary from project to project, and these elements may sometimes seem difficult to pursue simultaneously, but all of them are essential to develop true CHCA. Without being exhaustive, let us comment on a few key points. According to Werner, *"community-supportive* programmes or functions are those which favourably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage res-

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18. Respectively taken from "Conclusions and Recommendations", given in MFCB 89, p. 4, and "People's Participation...", in MFCB 64, p. 8.

19. Among the numerous books and articles—which sometimes speak of CHCA and PHCA while describing alternative systems, see for example "Community Health", "Health For All" (pp. 84-102), Bannerjee (pp. 4-9), Naik (pp. 10-24), Newell (pp. 191-202), Park & Park (pp. 10, 43-4 & 46-7), A.J. Patel (pp. 155-64), Rifkin (pp. 9-14), and Werner (in "Contact" 57, "Helping...", Front 1-3, and IA 127-8, pp. 26-31). The previous chapters have already said much about these characteristics, especially in the sections on PHCA and socialist countries (above, pp. 31-5 & 85-100). Useful figures and outlines can also be found in "Alternative Approaches ...", (pp. 195-6), and "Contact" 57 (pp. 3 & 12-6) and 67 (pp. 1-2).

TABLE 19

Basic Characteristics of CHCA

1.	Serving the needs (starting with the primary) of all people, especially the poorest
2.	Genuine participation (local committees, leaders, CHWs, etc.) of the people, especially the poor and oppressed
3.	Emphasis on "total health" and "total development"
4.	Emphasis on prevention and education
5.	Maximum use of local resources (personnel, technology, medicines, finances, traditional practitioners and drugs, etc.)
6.	Search for increasing efficiency (proper planning, training, supervision, referral system, etc.)[20]
7.	Concern for conscientisation and political action[20]

ponsibility, initiative, decision-making and self-reliance at the community level, and that build upon human dignity." In contrast, *"community-oppressive* programmes or functions are those which, while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian, paternalistic, or are structured and carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which, in the long run, are crippling to the dynamics of the community."[21]

The community programmes which "have been more or less successful in helping the poor meet their health related needs" "often have the following things in common": "1. Small, local beginnings and slow, decentralised growth. 2. Involvement of

20. The following pages explain why we include the last two characteristics.

21. In "Contact" 57, p. 5, and in Bang & Patel, p. 154; author's emphasis. The author however adds that he did not encounter any programme "in which every aspect was either oppressive or supportive. In each threre was a mixture of strengths and weaknesses..."

local people—especially the poor—in each phase of the programme. 3. An approach that views planning as a 'learning process'... (rather than following) a predetermined 'blueprint'. 4. Leaders whose first responsibility is to the poor. 5. A recognition that good health can only be obtained through helping the poor improve the entire situation in which they live."[22]

Community participation is nowadays recognised by most experts as the key to development and health care. Let us quote two enlightening passages. The 1979 FAO Conference stated: "Participation by the people in the institutions and systems which govern their lives is a basic human right and also essential for realignment of political power in favour of disadvantaged groups and for social and economic development. Rural development strategies can realize their full potential only through the motivation, active involvement and organization at the grassroots level of rural people, with special emphasis on the least advantaged." And the "International Convention on People's Participation in Development", held in Delhi in 1980, understood participation "as the growing of the people into persons with a critical awareness of their own situation, persons who are articulate, capable of making their own decisions and of organising themselves, guided by new values and imbued with a self-confidence to assert themselves in the face of oppressive elements in their society." *In many such declarations, participation includes a conscientising dimension and logically leads to people's organisation and political action, at least at the local level.* For "organizational structures are crucial if the community is to have any measure of power, or true control, or decisive involvement."[23]

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22. Werner in "Helping...", Front 1-2; author's emphasis. We have omitted the explanations of these characteristics. Werner's conclusions are based on his study of about 40 CHCA projects in Latin America, and on the analyses of other observers like D. Korten (op. cit.). The Pachod evaluation also stresses that this project is successfully carried out by and for the poor (Mukhopadhyay, in Benjamin, op. cit., part II, pp. 3-8).

23. respectively taken from IA 127-8, p. 2; Fernandes, pp. 179-80; and "Contact" 56, editorial. On participation, see for example "Community Participation" ("Unicef News" 98, 1978), "Contact" 56 & 57; "Health For All", pp. 92-5; Kaithathara, in "Social Action" 1981, pp. 351-7; and the issue 127-8 of IA. After an interesting review of some false concepts of participation, A. Bang adds that, *when the oppressed, the exploited and the needy*

Yet, it is also widely recognized that community participation still remains a rare phenomenon. There is even a growing disenchantment with this concept, apparently so difficult to implement.[24] In response, some writers argue that participation has hardly been tried and given a chance. For it was often wrongly understood, or at least practised, as "getting *those people* to do what *we* decide" in a top-down, vertical, almost military, approach, controlled by experts. It was promoted on Government's terms, not on people's terms. Control over medical knowledge and financial resources often led to control over people. And CHWs were often refused the responsibilities, money and skills necessary to operate efficiently...[25] These failures are unfortunately all too real, but one should not however defend the other extreme of unenlightened, and amorphous participation. *Authentic community participation requires proper leadership and coordination, and some scientific and technological inputs. It asks for a combination of firmness and flexibility, a real process of dialogue—perhaps something akin to the Chinese "mass line"...* One should not indeed enthusiastically support the Cuban or Chinese experience and, at the same time, vituperatively denounce the slightest input in CHCA projects!

Other writers, as already pointed out, *stress the intrinsic limitations of community participation and the absence of "unified" communities in a stratified and non-participatory society.* In our villages and neighbourhoods today, there are individuals, families, castes, classes, and ethnic, religious and political groups, but no "communities" as such. "Inevitably conflicts—between factions in the community, between professionals and community representatives, between funders and professionals, for example—are bound to arise whenever participation is ini-

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"understand the situation and issues by critical consciousness and take part in decision-making, implementation and evaluation of programmes and take the responsibility of the work as well as share in the benefits... it becomes people's participation." (in MFCB 64, p. 2).

24. For such ideas, see for example IA 127-8, pp. 3 & 26, and D. Naberro, in MFCB 91, pp. 1-2.

25. For these ideas, see for example IA 127-8, pp. 3, 21, 26-9 & 50; Werner, "Helping...", Front 2; and Kaithathara, in "Social Action" 1981, p. 354.

tiated." And CHCA projects "not only depend upon the good will and support of local leaders and power groups but also gloss over the class nature of the village communities and the hold of local powerful sections on distribution of welfare services (including health and nutrition). They... ignore the fact that the most crucial factor for participation, having a stake in the system' is altogether missing for the rural poor." How can there be, then, genuine participation in "communities" ridden with such conflicts of interests and power struggles?[26]

These criticisms, to a great extent, hold good for purely health programmes[27] and many so-called CHCA projects. *Authentic CHCA projects however take "total development" and even conscientisation into account, and can thus generate more participation. They moreover increasingly recognise the existence of conflicts and the necessity of siding with the oppressed.* Muller for example asserts that PHCA "can only succeed if it is taken as a militant concept, aimed at a redistribution of power and resources in favour of the poor." Since this "will not come about spontaneously," "the poor have to organize themselves to claim or even to enforce their rights. PHCA can and should contribute towards effective community organisation." "Therefore PHCA should not only be judged by its medical efficacy, but also by its political effectiveness." Werner comes down to practicals: "Effective programmes recognize and try to deal with the conflicts of interest that often exist between the strong and the weak, even in a small community. Not just local leaders, but the most disadvantaged members of society, play a leading role in selecting their own health workers and determining program priorities. *A conscious aim of such programs is to help strengthen the position and bargaining power of the poor."*[28] Though often with reluctance, effective programs and CHWs are increasingly drawn into different issues of social justice. *And a new kind of CHWs is emerging:* "These new health workers have

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26. For this paragraph, see Bang (op. cit., pp. 1-2 & 6), Naberro (op. cit., pp. 1-2), and Qadeer (op. cit., pp. 1-2).

27. In fact, both Bang and Naberro speak only of such projects.

28. These quotations are respectively taken from IA 127-8, pp. 7 & 12, and "Helping...", Front I. On this, see also J. Williams, in "Unicef News", op. cit., p. 31, and above, p. 117.

in common an intense commitment to the poor. They strongly identify with, and feel accountable to, those in greatest need. Their goal is health for all but health that is founded on understanding, equality, fair distribution of land, wealth and power, and political justice."[29]

On account of the prominent impact of socio-economic and political conditions and structures on the people's health status, *CHCA inserts itself into a process of overall development. This approach evidently involves a wide range of issues.* "By taking into account the causes behind the causes of poor health", "the most recent trend is now to include health care as but one sector of an integrated Development Programme which also covers education, community leadership, agricultural extension, communications and marketing improvements, intermediate technology, etc... If integrated development is to be taken seriously, and if a programme is really trying to confront the underlying issues which affect the health, well-being and future of a given people, it must, of course, take into consideration the socio-political situation, including the debilitating influence of paternalism and exploitation. Such considerations have led some rural heath projects to work through group dynamics to promote *conscientization* or social awareness and to become involved with land and social reform."[30] Approaches 3 to 6 of Table 16 indicate the various ways in which this integration has been pursued. *This new approach is difficult for specialists, but very normal for people:* "For people working in agriculture, health, education it is difficult to come to grips with the rhetoric of 'intersectoral collaboration, cooperation, coordination and integration'. For ordinary rural people there are no sectors: life is a unity of work, health, education, living conditions."[31]

The search for "total health" means an efficient integration of curative, preventive and promotional services.[32] Far

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29. Werner, in "Contact" 57, p. 4, and IA 127-8, p. 30.
30. Werner, in "Contact" 57, p. 4, quoted by Kaithathara, in "Social Action" 1981, p. 354. For lists of such issues, see for example Newell, pp. 31 & 92, and Williams, op. cit., p. 30. On this question of integration, see above, pp. 5, 32-4, 36-7, 87 & 97-9.
31. editorial in IA, 127-8, p. 3; cf. also Newell, pp. x-xi, 192 & 197-8.
32. On this, see for example "Health For All" (pp. 88-90), B. Mahadevan (in "Alternative Approaches...", p. 148), Newell (pp. 194-5), and above, pp. 32, 37 & 90-1.

from being opposed or separated, these aspects are complementary. Prevention and education are absolutely essential to attack the root causes of several health problems, and should undoubtedly get privileged attention. Yet, immediate curative needs, which become a top and even crash priority for the people in cases of emergencies, should be adequately met, and CHWs should be properly trained, and entitled, to deliver these services, thus acquiring much recognition and respect in the community.[33] *Medical care can thus serve as an entry point for prevention and education. The experiences of both socialist countries and CHCA projects moreover show the necessity of proper supervision and referral facilities.* In other words, CHCA or PHCA should not be interpreted as "second-class", "inferior", "primitive", medicine. "The goal is to set up a system where PHCA forms the base of a structure accessible to all, upon which other levels of care can be grafted and can develop."[34] As clearly exemplified by China and North Vietnam, the efforts to use traditional practitioners and medicines should be accompanied by a scientific programme of training, supervising and testing.[35]

The wide variety of CHWs and LHWs can be classified into two broad categories: the "auxiliaries" or "assistants", the "extension agents of a central system and authority"; and the "community-based workers accountable primarily to the poor", "the members of a community working towards greater control over its own development". Or, in other words, *the lackeys and the liberators.* The former have often limited skills and responsibi-

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33. It is widely recognised that health needs are usually a low priority for people. When serious sicknesses occur, they however become a high priority. On this, see Banerji (in "Poverty...", p. 221) and Newell (p. 195). *"In health the most felt need of the community is for medicine and it is necessary that the health-worker has the required knowledge, skills, attitudes, and means to meet this need at all times." This is what the community expects* (Kaithathara, in Volken, "Moving...", pp. 63-4; cf. also Werner and R. Maru in Patel pp. 156-7 & 191). Without denying the essential role of prevention, some experts now speak of "more curative medicine" (for example IA 127-8, pp. 9 & 46-8).

34. J. Williams, op. cit., p. 31, and K.G. Rao, in "Alternative Approaches...", p. 195.

35. V. Kochar, S.M. Marwah and K.N. Udupa argue for such a venture in India (in "Alternative Approaches...", pp. 201-17). On this, see also "Health For All", pp. 98-9.

lities and, in any case, very much depend on the health professionals and administrators. The latter usually possess a wider range of skills and responsibilities, and are much more community-oriented. *Rather than being second-class or substitute doctors, they are "inside workers-for-change"*, "not only for health care, but for the awakening of people to their human possibilities... and finally to their human rights." They are catalysts, facilitators, conscientisers. They speak out for the "voiceless" poor. They must share their knowledge with their people and help them not only to answer their immediate problems, but also to "look ahead, and work together to overcome oppression and to stop sickness before it starts." According to Werner, *"the great variation in range and type of skills performed by VHWs in different programs has less to do with the personal potentials, local conditions or available funding than it has to do with the preconceived attitudes and biases of health program planners, consultants and instructors."*[36]

It is often claimed that CHCA projects should be economically self-sufficient. And this is almost presented as a key goal. Efforts in this sense are surely welcome and the poor should be "charged a little so that they do not become the objects of charity and pity". Yet, two major pitfalls should be avoided: "charging the rich to gain more income", which generally "ends in serving primarily their needs and priorities"; and charging the poor more than they can reasonably afford, thus excluding them from needed services or burdening them with privations and debts. This is unfortunately the outcome of many—and probably most—voluntary institutions. Such attempts

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36. For this paragraph and quotations, see IA 127-8, p. 44, and Werner, ibid., pp. 28-31, and in Bang & Patel, pp. 151-86, and "Helping...", Front 2-3. For details on CHWs and LHWs, see the excellent articles of R. Maru ("CHW: National Experience", in Bang & Patel, pp. 177-94), D. Werner ("VHW—Lackey or Liberator?", ibid., pp. 151-66, and "Participation and Accountability of CHWs", in IA 127-8, pp. 26-31), and J.P. Vaughan ("Barefoot or Professionals? CHWs in the Third World", in MFCB 70, pp. 1-4 & 7). The last article contains an enlightening review of "some important questions concerning their function, utilization, selection, training and evaluation". For useful suggestions on a conscientising training, see the articles of Kaithathara (in Volken, "Moving Closer...", pp. 59-73, and "Learning...", pp. 63-90; and "Social Action" 1981, pp. 351-7), and Werner, "Helping...", ch. 26.

at self-sufficiency moreover divert CHCA projects from their original purpose of improving the health of the vulnerable people. If health for the rich is heavily subsidized—and it is!—, why not also health for the poor? And if the Government offers free health services, why should CHCA projects make the poor pay? According to Bang, "no community health project which is predominantly preventive and educative in nature and which serves mainly the poor can become economically self-reliant. All such claims need to be reexamined for they create illusions. Projects should try to generate income either through economic programmes or from committed supporters who have money to donate for the cause."[37] These strong words may help us *to rethink our glib acceptance of economic self-sufficiency.*

This presentation of the major characteristics of CHCA has probably placed in too sharp a focus the socio-economic and conscientising/political elements. Table 16 shows that these dimensions can in fact be given various emphases. Yet, as we already pointed out, *it is precisely these elements that optimise the contribution of CHCA and obviate its dangers...* In conclusion, it might be good to repeat that health should be pursued "in the context of an *enlightened, organized, participatory* and *self-reliant community* working towards *total human development* and *liberation...*"[38]

CHCA demands much from health professionals: "A lot of pain and frustration accompanies our de-schooling and re-schooling process. We have to undo practically everything that we have learned, and face the lamentable fact that we are totally unprepared to answer the health needs of our people. We have to review and study more on tuberculosis, schistosomiasis, malaria and other communicable diseases. Our work has to emphasize health education, sanitation and hygiene, maternal and child health care, use of medicinal plants, and traditional massage. And we have to do research and documentation on our indi-

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37. For this paragraph, see A. Bang, in MFCB 64, pp. 6-8. We have already mentioned another of Bang's suggestions in footnote 14. Newell also cautions against an unrealistic support of self-sufficiency (pp. 195-7).

38. This is the philosophy of the Makapawa programme in the Philippines ("Contact" 56, p. 5). The passage adds: "in order to become an authentic Christian community".

genous forms of medicine. To make our communication and training methods more effective, we must translate scientific medical jargon into a language more understandable to the people. We have to learn from the people, especially from the traditional healers."[39] One should add: "We must be involved in broad socio-economic and political issues..."

Conscientisation, Political Action and Health

Several previous passages expressed the possibility and even necessity of using health issues—along with other issues—to conscientise and organise the people. Let us now analyse, in a more explicit and systematic manner, the potentials and limitations of this approach. The basic problem can be described as follows: "Health for and by the people cannot become a reality fully except in a society that is 'healthy' in its structures and its institutions. *The question then is: how can community health work contribute to the transformation of the whole of society?" Or, in other words: "What health action has meaning and relevance in the broader national struggle for health and social justice"? What health action attacks the root causes of ill-health?*[40]

Many writers have lately emphasised that health work should include conscientisation and organisation, and at least sometimes lead to direct political action. Approaches 5, 6 and 7 of Table 16 represent various possibilities, and degrees of involvement, in this field. According to Kaithathara, "health education and community health can play a vital role in increasing people's consciousness not only about their health needs but also about the evils in society which are the main causes of their sickness and ill-health." "Even illiterate, trained health workers are quite capable of reaching a critical understanding of the functioning of society." "Community health should also be a way to motivate and mobilise the people to resist the domination of the traditionally powerful."[41]

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39. J.Z. Galvez-Tan, in IA 127-8, p. 24.

40. Kaithathara, in Volken, "Learning...", p. 64, and Zurbrigg, ch. 8. For this section, see especially Werner ("Helping...", ch. 26) and Zurbrigg (ch. 8). *CSA booklet 13 explains the meaning and scope of conscientisation.*

41. in Volken, "Learning...", pp. 65-7.

In Werner's experience, "health activities become an important tool raising awareness and organising the people." And there are already programmes where the CHWs' chief role is to assist in the humanisation or conscientisation of their people.[42] Abhay Bang asserts that CHCA projects "can be media for conscientisation of the medicos and of the masses", and Anant Phadke that "conscientisation about the medical system is as important as other aspects of medical work." For Andrew Clerk, the underlying purpose of medical work is to assist in the removal of poverty. And "poverty is not the lack of medical services as such, but the absence of power flowing through the veins of the poor." Broadly speaking, "poverty is powerlessness" and "the usual basis of power for poor people is organisation." "Medicine is a small, but important, sub-system" and it "may be *a practising ground for newly organised people to try... (various) social actions.*"[43] F. Muller and D. Werner therefore conclude that CHCA projects should be judged by their "political effectiveness", that is, their contribution to the redistribution of wealth and power in favour of the poor and oppressed.[44]

In this context, *CHCA is often presented as an entry point for initial contacts, human development, leadership training, conscientisation and organisation, and even sometimes, direct political action.*[45] The groups represented at the "International Convention on People's Participation in Development" in the fields of non-formal education, social housing, CHCA and women's development, for example *"viewed these inputs only as tools for the education and organisation of the oppressed groups* who alone could become agents of change in their society"; they wanted to go beyond their respective entry point. In the words of A. Madiath, "we constantly used our involvement through

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42. in "How" 1982 no. 3, pp. 15-8, and in Bang & Patel p. 164. In this interview, Werner gives a moving account of a Mexican community's growth in critical consciousness (cf. also "Helping...", Front 7-12, and MFCB 69, pp. 1-4 & 8).

43. respectively quoted from Bang & Patel (pp. 223-4), MFCB 82 (p. 8) and 67 (pp. 2 & 7).

44. in IA 127-8 (pp. 7 & 12) and Bang & Patel, p. 159.

45. See for example Kaithathara, in Volken, "Learning...", pp. 66-7; MFCB 26, pp. 2-3, and 67, p. 2; "How" 1982 no. 3, pp. 11, 12, 14 & 17; and H. Sethi, op. cit.

'health' to build up awareness in the community on other aspects of their lives," *"We succeeded with the entry point* because it was (1) broad-based and brought us into close contact with all sections of the village community; (2) met immediate needs of people; (3) it was slow, steady, non-aggressive and kept pace with the people's acceptance of us as strangers." It gradually worked towards "a wider awareness building process" and led to the tackling of important socio-economic and political issues. At that stage, the work spread rapidly.[46] Each entry point "has the capacity to create a new atmosphere within a depressed community and to awaken new aspirations of self-realisation in an oppressed people. A base is laid which makes 'development from below' possible, enabling the people to get organised, to gain bargaining power and gradually transform their numerical strength into political power."[47]

In more theoretical writings, *Banerji sees the struggles for CHCA and health justice as a lever for broad socio-economic and political changes.* "While it is now being gradually realised that it is unrealistic to expect improvement in the health status of the population of a country without appropriate political, economic and social action, it is often overlooked that efforts to alleviate the suffering caused by health problems can, in its turn, contribute to the initiation of such action." This is particularly true for CHCA. "In the first place, the very alleviation of suffering has political significance because, at least in this field, it narrows the gap between the ruling classes and the masses. Because of this the masses are in a somewhat more advantageous position to wrest their rights from the ruling classes. Secondly, the health services also provide an entry point to change agents who would make use of this opportunity to work with the people to initiate changes in the other social and economic fields. Promotion of alternative health care system may prove to the people

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46. Fernandes, pp. xxv & xxxi-ii, and Madiath, ibid., pp. 105 & 121-2.

47. Volken, in "Learning...", pp. 11-2. The author remarks that each entry point has its own specificity (pp 113-4). Health is often particularly relevant for the conscientisation of women (R. Bang, in Bang & Patel, p. 89). For a critique of "health as entry point", see Zurbrigg, ch. 8, part 2. The author emphasises the danger of dependency and the difficulties met in moving beyond the entry point.

that they can create better conditions for solving their health problems. By generating such social awareness health work may turn out to be a lever for promoting similar developments in other social and economic fields, such as: education, employment, land reforms, cooperative movement, legal protection and social justice. In short, it has the potential of initiating a chain reaction which will lead to a rapidly increasing democratisation of the masses. *A campaign for active promotion of a people oriented alternative health care system thus in fact becomes a potent tool for pressing for change in the political system."* Political parties and community organisations should therefore utilise the present concessions of the Government to pressurize for more radical changes in health care and society.[48]

Local conscientising and organising efforts progressively provide the poor with "some free space in society where they can breathe more freely and begin to stretch themselves." They *"create a base for joint action* which is relatively free from the control of the locally powerful."[49] Such efforts should however give rise to *a broad people's movement.* The "International Convention on People's Participation in Development" therefore states: "The educational process that begins with these aspects of human reality much finally culminate in a nation-wide people's movement with a threefold aim. The first is their acquiring power to wrest for themselves their basic human rights and their rightful place in society. The second goal of the movement will be to put an end to the control by the few over housing, health, education and other human needs. Finally, the

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48. On this, see Banerji, in MFC Bang & Patel, pp. 143-9; "Poverty ...", pp. 223-4; "Political Economy...", pp. 27-30 & 38-9; and in Naik, pp. 37-8 & 45-6. On Government concessions, see above, p. 81. Author's emphasis.

49. Volken, "Moving Closer...", p. 78. The conclusion of this book explains the step by step approach of local action groups (pp. 75-9). According to Werner, "it often makes sense *to combat injustices in one's own community before taking on the giant problems outside.* First groups of villagers, then groups of villages, can begin to help the poor gain more control over their health and their lives. A process of social *evolution* (gradual change) begins, which may prepare the way for social *revolution* (complete structural change of the whole society)" (in "Helping...", ch. 26 p. 36; author's emphasis). On this, see above, pp. 106-7.

movement will create new values in order to influence changes in a culture to ensure greater respect of persons."[50]

Ultimately, trade-unions and political parties should shake their lethargy and take up such grassroots demands.[51] In this way, the people's struggles for their health—and other—needs will be grounded in a mass-based political movement and linked with the struggle for a socialist society.[52] *Qadeer and Zurbrigg go further and emphasise the necessity and priority of well-organised political struggles.* Qadeer criticizes Banerji for his utopianism, which mistakes spontaneous mass actions for planned political struggles, and points out that "a secondary lever for political change, that is, health services, must not overshadow the primary lever which is the struggle of the people for control over resources and their distribution." "Health programmes have only a supportive role in the political actions of the working people." While recognising the usefulness of "reforms that bring about some relief to the people... even within the constraints of the existing system", those who want to change today's society should therefore adopt, as primary concern, the strengthening of the working class movement and situate their health efforts in this framework.[53]

In practice, the work of conscientisation and organisation has to be carried out at several levels. Village- or neighbourhood-level awareness enables people to confront local issues and oppressors. Besides being involved in non-health questions, *larger organisations can demand "the proper implementation of those government services, including public health and drinking water, to which they are entitled", and fight corruption and*

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50. "Conclusion", in Fernandes, p. 180. On the need for such a movement, see for example "Health For All" (cf. above, pp. 39-40), "How" 1982 no. 3 (editorial), Naik (pp. 25-6), and Phadke (in Bang & Patel, p. 245).

51. On the failure of political parties in this area so far, see "How" 1982 no 3 (editorial) and Banerji, "Poverty...", pp. 222-3. For an experiment of "Health work in a working class movement", see MFCB 82, pp. 6-7.

52. On this, see for example Bannerjee (pp. 3 & 35-6) and Zurbrigg (ch. 8, parts 3 & 4).

53. In "Social Scientist" 1980, no 91, pp. 34-6, cf. 21-37. Zurbrigg thinks along the same lines.

inefficiency among public servants. They can pressurize for accountability. Rather than establishing substitute services—over which continuation the people have usually no firm control—, *health professionals should directly participate in such agitations protests.* They should also support these struggles by informing the people about Government programmes and the results of social health research— "necessary evidence when it appears as medical symptoms, of the systematic deprivation, exploitation and harrassment from which the poor suffer". *These issue-oriented struggles do not aim at transforming the health system, but at implementing the already recognised rights.*[54]

At a broader level, systematic efforts should be made to conscientise the various health professionals—through societal health analysis and concrete experiences in CHCA products—*and the general public.* So much can, and should, indeed be done to expose the injustice of the present health system and its ideology, and to contribute to a social and political interpretation of ill-health. *While focusing on non-health targets, political parties, trade-unions and other mass-based movements can and should struggle for better health policies and even an alternative health care system. Health professionals should involve themselves in such people's movements and help them to identify, formulate and adopt the relevant health demands that will really benefit the poor and oppressed. This will be their professional contribution to people's movements and struggles.*

We may end this section with *two convincing calls for a broad involvement.* Galvez-Tan writes: "We did not realize that working among the people would demand new roles for us. We were trained in medical practice, but the situation called rather for someone in the role of a change agent with special skills in health care. To be a change agent, we have to be a community organizer, catalyst, teacher, learner, researcher, conscientiser, co-ordinator, supervisor and health worker, all at the same time. We learn how to arouse and organize the people, systematizing their experiences, feelings, skills and action as well as their dreams so that they can mobilize themselves to move out of their dehu-

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54. The quotations are from Clerk, MFCB 62, pp. 2 & 7. On this, see also Zurbrigg (ch. 8, part 4) and Banerji (in "Political Economy...", p. 29, and "Poverty...", pp. 222-3).

manized conditions." "My work with the peasants" has awakened me to the deep need of fundamental structural changes. "How will a Filipino doctor answer this challenge? I am a Filipino doctor. What can I do to change this situation? I would like to think of myself first as a Filipino and only secondly as a doctor, and this means going beyond medicine and health... Doctors who consider themselves Filipinos first and doctors second cannot remain apolitical—we must be aware of what is happening around us and try to be of greater service to the people. This means uniting with... (other groups) in their struggle for nationalism and democracy. Our expertise in health must be devoted to that wider struggle."[55]

Werner is no less eloquent. Speaking of his experience with Mexican villagers, he concludes: "The cruel and unnecessary hardships these people suffered were not simply because they were poor, but because they were on the bottom, because they were stepped on, belittled, cheated, and exploited time and time again. Such is the lost of most of mankind. To separate such needless suffering and its human causes from what we call 'basic health needs' is to separate our minds—indeed, our hearts—from our bodies. It is to add our seal of silent approval to the abuses of man by man. If such talk is political, let it be so. I will stick up for the interests of man. The poor first. But ultimately for the interests of all mankind, rich and poor. For unless man learns soon to overcome his greed, his greed will soon overcome him. We must learn to be kind. We must learn to let others have an equal share and an equal chance. We must learn to be more truly and wholly human. This is what health—and healthy politics—is all about... Clearly, alternatives are needed; alternatives that restore dignity, responsibility, and power to the people on the bottom; alternatives that allow and encourage the poor to analyse the whole physical, social and political reality of their situation and to organise so that they gain, through their own actions, greater control over their health and their lives."[56] We must therefore work with courage to make these alternatives a reality.

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55. In IA 127-8, p. 25.

56. in MFCB 69, p. 8.

Conclusion

Time has now come to sum up our findings. The current thinking and debate on health has brought about a *certain shift in the pattern of health involvements*. Let us review the situation with the help of Table 16 (or 20). A growing number of *health professionals* are nowadays choosing approaches 2, 3 and 5a as their focus of action. Most of these hold that health professionals should mainly work in the health field.[57] A smaller, but also growing, number of health professionals are even focusing their attention on non-health questions and moving to the other approaches. Most of these become involved in 4 or 5b, and a few in 6; very few put aside direct health programmes to dedicate themselves fully to 7. Comprehensive health care programmes most often resort to approaches 3 and 4, and sometimes to 5. On the other hand, more *development workers and social activists* than before become involved in health programmes and issues and thus adopt approaches 4, 5b, 6 and 7.[58] Since reality

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57. A. Bang for example writes that, *"even when it is a part of a comprehensive project, the community health programme has the primary objective of achieving better health* (with some marginal contribution to political, economic development)" (in MFCB 64, p. 8). And Naberro similarly states: "Rather than concerning themselves almost uniquely with complex issues that have implications outside the medical professional sphere, international medical organisations would do better to concentrate their efforts on promoting improved provision of curative medical care and public health services throughout the world. They need to provide maximum support to those who are trying to counter the vested interests inside the medical professions that work so effectively against this objective." *Their operational objective should be "'Medical care for all by the year 2000'. The aim should be to provide good, appropriate, accessible, effective curative care and public health services and to train and supervise doctors, nurses and auxiliaries to provide them."* Such activities "can be put into practice by the medical profession. These are very different from the activities which might one day lead to health for all, and in which the majority of medical professionals can only play a very limited role." *"Health for all" should be the vital goal of development workers, not of health professionals* (in MFCB 91, pp. 2-3).

58. On this phenomenon of getting involved outside one's profession, see for example Arole (in Fernandes, pp. 27-8), Newell (pp. 197-8), Zurbrigg (ch. 8, part 2); and the quotations of the

is much more complex than our theoretical schemes, many involvements and projects are evidently difficult to classify rigidly in one of these categories, and some may even shift their focus of action according to circumstances. It should finally be emphasised that *each of these approaches implies a specific role and thus requires different qualities and skills.*

But how to assess the potential of these various health involvements? Table 20 outlines their respective achievements. *Each approach possesses a focus of action—some primary goals, objectives and strategies—and its potential/contribution corres-*

TABLE 20

Potential of Various Health Involvements

1.	Curative network: care of sick
2.	Health programmes: care of poor who are sick and small impact on the community's health conditions and human development
3.	CHCA (with CD): as 2, but greater impact... and small economic benefits
4.	CD (with CHCA): as 3, but still greater impact... and greater economic benefits
5.	a) CHCA (with CD & conscientisation): as 3 ... and initial steps towards structural changes b) CD (with CHCA & conscientisation): as 4... and greater steps towards structural changes
6.	Conscientisation (with CHCA/CD) : less direct health & economic benefits than 3, 4 or 5, but direct action towards structural changes
7.	Conscientisation/political action...: no direct health and economic benefits, but more direct action towards structural changes.

two previous paragraphs. Werner for example does pioneering work in the field of CHCA and of health conscientisation/politics without being a doctor.

ponds to its framework. Let us highlight a few points. From approach 2 onwards, there is a welcome emphasis on the service of the poor, for example work in slums or villages, and/or care of vulnerable groups like infants and mothers. Approaches 3 to 6 bring about various degrees of improvement in the community's health and socio-economic conditions, and in its human development. And approaches 5 to 7, once again in varying degrees, make direct contributions to structural changes. In our opinion, *each approach performs some useful functions and has therefore a certain relevance.* For the care of the sick—whether rich or poor—is a value in itself and should be ensured in all types of society. *In fact, these approaches are complementary and should coexist and strengthen one another, in any given society.*

One should however think in terms of maximum rather than minimum relevance. Though it is difficult to compare achievements of a different nature—as for example care of the sick, prevention and health education, human development, and structural changes—, *there is indeed an objective hierarchy of relevance.* In spite of divergences of views on some issues, our analysis leaves no doubt that the provision of health care to the poor is a great step forward. And that CHCA, socio-economic programmes, and conscientisation/political action constitute other significant steps. *The tragic situation of our people and the values of humanity and justice make it imperative that every individual, group and organisation take these priorities into account. Even those who remain mainly involved in the curative network must open their eyes to these broader dimensions and collaborate with those who follow other approaches. While making their specific contribution, they must possess a proper perspective and vision. On the other hand, the consideration of these objective needs and priorities for action should lead many individuals and groups to move beyond purely professional and sectoral concerns and to assume new approaches and responsibilities.*

Each approach undoubtedly contains its own limitations and dangers—as for example the creation of additional dependency, the monopolisation of the services by the rich, the strengthening of the system, etc.—, but these should be fought against and obviated by the clear orientation of the social activists and health professionals, the genuine participation of the poor and oppressed, and a constant concern for conscientisation. *Our study*

therefore concludes that there are several meaningful and complementary involvements in health programmes and issues, but also that these involvements possess various degrees of relevance.[59] The objective criteria we have mentioned, the particular needs of a community and its degree of critical consciousness and one's capacities and training, are all important factors to choose one's approach. *While trying to become more and more meaningfully involved*—the final conclusion will consider the concrete implications and challenges of our findings—, *each group and individual must possess an overall vision and support those who adopt complementary approaches.*

Our approach, that is, our primary goals and objectives, largely determines the framework in which we work and the potentials and limitations of our action. *But other factors are also of crucial importance.* According to Volken, *it is ultimately "the type of animators that influences most directly either the slow or the rapid advancement of the people."* And, for Werner, *"it is not the stated goals and objectives of a community programme that make it vital or viable—but rather the vision, unwritten and evolving, shared by the members of the programme and community as they change and evolve together." This vision "is the dream of where we would like to go."*[60]

An enlightened and inspiring vision will enable us to confront the unavoidable obstacles. Neither CHCA nor conscientisation is easy. "We should not be surprised that improving the health of the least healthy people in the world is difficult. We should not expect that it will be easy—or inexpensive—to provide widespread health care services, change people's lifestyles through health education or elicit people's participation in their health care. These are all political activities: they require action by groups and communities; they are concerned with the distribution of power between different groups in society, between profes-

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59. According to us, *approaches 1 to 4 are relevant—though in very different degrees—as long as they contain a conscientisation component and remain open to political issues* (*approach 5*). One can therefore take them, especially CHCA and CD, as a focus of action. One can also meaningfully adopt approaches 6 & 7, but emergencies may call for medical care.

60. respectively taken from "Learning...", p. 114, and "Contact" 57, p. 1; author's emphasis in the last quotation.

sionals and the people they serve. The implementation of the activities embodied in PHCA programmes inevitably involves conflict."[61] And this is much more true for programmes in which conscientisation and direct political action constitute the focus! But *we must learn to face these difficulties and do whatever is possible within the existing constraints. This is how the future will be built...*

"The seeds of change are already taking root. There are signs—in many small groups and personal ways—that humankind is on the verge of a critical awakening. As the working people and poor become more aware of their rights, the repression by those in power grows more severe. But cruel repression only awakens people more quickly to the call for change. And little by little, those at the bottom are awakening. Small, independent, community-based health programmes in many parts of the world are playing a key part in this process."[62] And whole countries, as we saw, have also moved in the proper direction... *We are invited to reflect on our values and attitudes, choose a relevant approach and make our own contribution!*

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61. Naberrø, in MFCB 90, p. 4.

62. Werner, in "How" 1982 no 3, p. 29.

Conclusion

The Concrete Challenges

This book does not hide the complexity of health issues and the diversity of views. Yet, it also leaves no doubt that many things have become clear: for example, the magnitude and urgency of the problems; the inefficiency and injustice of the present system; the impact of various socio-economic and political factors on health (food, water, sanitation, housing, and consequently employment, wages, land distribution, representation and participation, etc.); the need for a radical reorientation of priorities, budgets, and training of all health professionals and workers. In this light, it is undeniable that *a major and immediate shift should be made in favour of the poor, and especially towards rural areas and backward and vulnerable groups. And that significant improvements in health conditions and in society as a whole will only take place when the people come forward and assume responsibility for their own development and health.* The people must express their needs and priorities at all levels. Health for and by the people is absolutely essential. The CHCA approach has therefore to spread everywhere and the people have to become conscientised about health and other issues so as to take charge of their lives and build various types of organisations to work for justice in every field of life.

Our nation is undergoing an overall crisis of confidence. In this context, most health professionals pursue their ordinary activities in the present system, but without a sense of deep achievement and a conviction of contributing much to the building of a better nation. And the more socially enlightened among them risk to become paralysed by the immensity of the problems and their uncertainty about relevant action. It is however our contention that *the possibilities of meaningful involvement are clear enough for all to come out of their indifference, lethargy and discouragement and to rediscover a new sense of direction and purpose.* To remain passive and silent makes us partly responsible for the continuation of the evils that exist in the health field and in the society at large. Not to oppose the sytsem means

to support it, at least in practice. *Time has come for each individual, group and institution to confront the basic issues and to make the required decisions.* The insights contained in this book have indeed very concrete implications and challenges for all of us.

These challenges first of all concern us as individuals—whether one is a doctor, nurse, development worker, social activist or an ordinary citizen. Here are some of the questions one must personally answer. How can I concretely make an option for the poor and put my capacities and skills at their service? How can I promote CHCA in my sphere of work? How can I spread a proper understanding of health issues, conscientise others around me, and take part in political action for better and more just health services? How to change my own ideas, values and attitudes towards health and health care and free myself from my class biases? How can I develop a proper vision and perspective? Besides such questions that may already bring some significant changes in our present work and life, there are still more challenging ones. What should indeed be my priorities and focus of action? In other words, what should be my own approach? Taking into account not only my personal background, experiences and skills, but also the people's needs, and the objective hierarchy of relevance spoken of in this book, where should I work —in what area and with what target groups?—and with what institutions or groups? And how can I efficiently collaborate with those who follow complementary approaches? How can I remain concerned with broader issues, while making my specific contribution?

Various institutions—such as hospitals, dispensaries, research and training centres, etc.—are also deeply challenged by the findings of this book. Here are some of the questions they face. How can they contribute to the reorientation of the health system towards the poorest sections of Indian society, and to the spreading of CHCA and of conscientisation/political action with regard to health? In particular, how can existing *dispensaries and clinics* promote CHCA, work in collaboration with other individuals and groups and help to conscientise and organise the people? How can *hospitals*[1] learn to see beyond the immediate wants of their

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1. For some suggestions concerning the transformation of hospitals, see for example "Contact" no 20. April 1974, and F. Houtart,

patients, become involved in people's problems, and encourage community participation in hospital decisions? How can they contribute to the establishment of outreach centres where basic services are provided? How can their personnel and facilities truly serve the poorest sections, at least much more than now? How can hospitals promote health education? How can they transform themselves into referral centres and become models for the future? And how can the various *training institutions* for doctors, nurses, CHWs, etc., really expose their trainees to the health needs of our country, give them a genuine experience of CHCA, and provide them with a proper societal health analysis? What training programmes will conscientise the future health professionals and workers about larger issues and prepare them to become community animators and organizers and to work as a team with the people and other development workers and social activists? And how can our *research programmes* be truly focused on India's health needs and the integration of modern and traditional medicine? *All the institutions that sincerely want to serve the people's needs must devote enough time to reflect on these issues and decide their future course of action. In some cases, they must even question whether they should not close down and become involved in more relevant approaches.*

Voluntary organisations, action groups, religious congregations, and even broader organisations face such important challenges. Efficient hospital and curative services, as well as specialist care will always be needed. What is wrong is not that such services exist, but that they are unequally distributed, and that more basic needs are not met and more essential services are not provided. In consequence, what should be the main approach or focus of action of your *group/organisation or religious congregation?* How to turn yourself towards the most needy? What does today's emphasis on CHCA and conscientisation/political action concretely mean for you? What target groups and areas should you mainly serve? In what institutions or projects should you be involved? What % of your members should be in each of these? Should some members of your group/organisation or religious congregation work in Government institutions—as for example

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G. Lemercinier & M. Legrand, "The Catholic Hospital System in India", cyclostyled document, ISI Documentation Centre, pp. 24-7.

hospitals and PHCs—and try to transform them? If there are greater needs than those you presently meet, and better services than those you provide, how to reorient your work? Do you possess the courage to close down or hand over less important services and institutions to begin more relevant ones?[2] And how to ensure that all your members have a proper understanding of today's issues and are properly conscientised, motivated and involved? *Broader organisations like trade-unions and political parties* have moreover to discover how they can reflect and support people's aspirations for better health and better lives, and integrate people's demands in their movements.

The socio-economic, political and ideological structures of our country impose limitations in our work. This is true for both CHCA and conscientisation/political action. But how can this situation be changed? By starting where we are and using every possibility for transforming action! *The only means available are CHCA, conscientisation, and various people's movements and organisations, and we must learn how to use and develop them.* Vested interests and reactionary/conservative forces will undoubtedly oppose radical changes in health and other fields. But, once again, how to change this situation? *The only way is to counteract these forces by uniting the people in their action.* This book has presented and assessed various possibilities of relevant action. *It is now our responsibility to take a stand, choose our approach and make our contribution.*

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2. Houtart/Lemercinier/Legrand recommend *"a moratorium on construction and development of big hospitals in order to consecrate the human and material resources available" to the vital needs of the poor. "In the same line, it would be good to help the religious congregations who desire to retire from these institutions to realise this project,* in spite of the resistance which they might encounter" (op. cit., pp. 26-7).

Appendix—I

TABLE 21

Voluntary Health Care Institutions

	Catholic	Protestant	Total**
Hospitals	481*	333	1355*
Dispensaries	722*	96	932
Beds	36,423*	35,129	73,886
Personnel	11,671	18,845	30,516

—This table is compiled from "Voluntary Hospital Directory", VHAI, 1974; "Directory of Voluntary Health Care Institutions", VHAI, 1981; and a letter of J. Vattamattom, Executive Director of CHAI. *These data are for 1983 and 1981 (1355), while the other statistics are for 1974. **The figures do not tally because they refer to different years; and also on account of the existence of voluntary institutions which are neither Catholic nor Protestant. In 1974, the percentage of hospital beds in the voluntary sector was about 23% of the total in the country, and that of Christian beds 18.5%. According to a 1973 survey of 285 hospitals, the Catholic beds were then distributed as follows: rural (44.1%), urban (28.7%), semi-urban (20.3%), and non-specified (6.9%). The staff distribution favoured the urban public. For these and other details, see Houtart/Lemercinier/Legrand, op. cit.

Appendix—II

The New Vision of CHAI*

In July 1983, the working team of the "Community Health Department" of the Catholic Hospital Association of India (CHAI) described *the new philosophy and vision of CHAI* as follows:

"1. Health is the total well-being of individuals, families and communities as a whole and not merely the absence of sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met. Accordingly *a new set of parameters will have to be considered for measuring the health of a community* such as the people's part in decision making, absence of social evils in the community, organising capacity of the people, role the women and youth play in matters of health and development, etc. other than the traditional ones like IMR, life expectancy, etc.

2. *The concept of Community Health ... should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right.* Thus it is beyond mere distribution of medicines, prevention of sickness, and income generating programmes.

3. In a country like India, so vast and varied, where 80% of its population live in the rural areas and about 90% of the country's health care system caters to the needs of the urban minority, *a new orientation and re-thinking of the whole health care system is the need of the hour.*

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* Vattamattom John, "Community Health Programme—The New Vision of CHAI", cyclostyled document, 20 July, 1983. This document, which comprises a plan of action, is presented as a guideline to ensure CHAI's contribution to the attainment of "health for all by the year 2000 AD."

4. The present medical system with undue emphasis on the curative aspect tends mainly to be a profit-oriented business, and it concentrates on 'selling health' to the people, and is hardly based on the real needs of the vast majority of the people in the country. *The root causes of the illness lie deep in social evils and imbalances, to which the real answer is a political one, understood as a process through which people are made aware of the real needs, rights and responsibilities, available resources in and around them, and get themselves organized for appropriate actions.* Only through this process can health become a reality to the vast majority of the Indian masses.

In the light of the above conclusions, we identified the *exploited and the unorganised masses, particularly in rural areas as our target group."* This target group should be reached through CHAI institutions and in collaboration with similarly oriented institutions and groups. The study of *"this new concept of health should form an integral part of the curriculum in seminaries and religious formation houses. The same ... holds good for all our educational institutions."*

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THINK IT OVER

* "Health IS NOT mainly an issue of doctors, social services and hospitals. It is AN ISSUE of social justice. It is an issue of who gets what available resources... The health of a people is intimately related to their income, to their education, to their job opportunities, etc. If ... poor health patterns ... are to be changed, then changes must be made in the entire social-economic-political system in any given community."

Christian Conference of Asia, 1977

* "The health of the people is far more influenced by politics and power groups, by distribution of land and wealth, than it is by treatment or prevention of disease... If our goal is truly to get at the root of human ills, must we not also recognize that ... health projects and health workers are appropriate only if they help bring about a healthier distribution of wealth and power ?"

David Werner

* "We want our health services to take primary health care to the masses, particularly in the rural and urban slums. Catholic hospitals and dispensaries should stress the preventive and promotive aspects of health care."

Catholic Bishops' Conference of India, 1978

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